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ORIGINAL ARTICLES.

THE PREVENTABLE DEATHS OF CHILD BIRTH.*

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This subject was brought to my mind by the death, in another State, of a lady 23 years old, an only child, married but little more than a year, and under circumstances which I think you will all agree could be the result only of gross neglect on the part of the physician in charge. When this lady was seven and one-half months pregnant, I learned through a mutual friend that the family were greatly worried because she was bloated, especially in the face and hands. The confinement was expected about January 1, and since the last meeting of this Association, I have learned of her death.

In this little state of Rhode Island, during 1891 (the last report to which I had access) thirty-two women lost their lives in child birth. Though not exactly *apropos*, I cannot help quoting Dr. Helen W. Bissell in the *Northwestern Lancet*. She says: "Some may argue that accidents occur only once in fifty or one hundred times, but I think if one in fifty or one hundred passenger trains ran off the track there would be a loud call for a somewhat different management."

The preventable deaths in child-birth I hold to be from post-partum hemorrhage, puerperal eclampsia, and puerperal fever. Deaths from exhaustion are not occurring in recent years with the universal knowledge of the use of forceps and other

means for hastening delivery in the interests of the mother. Neither do I wish to include deaths from placenta prævia among those preventable, though probably in no class of abnormal cases of child-birth does so much depend on the judgment and experience of the attendant as in those in which the placenta is prævia. The treatment, however, is no more preventive of death than is tying an artery that is wounded. So might craniotomy, Cæsarean section or symphysiotomy be likened to an amputation for malignant disease, though the dangers from these formidable operations might be avoided by the frequent use of the pelvimeter.

The almost universal cause of post-partum hemorrhage is a relaxed state of the uterus. After the child is born it is usual for the uterus to remain at rest for a time (perhaps twenty minutes) when contractions for the purpose of separating and expelling the placenta begin. As the placenta is separated from the uterine wall, the blood vessels are closed by the peculiar arrangement of the muscles and blood vessels. The time elapsing between the birth of the child and the birth of the placenta may be diminished by stimulating the uterus to contract by rubbing it when contraction occurs, hastening the expulsion of the placenta by compression after the manner of Credé. While too early separation of the placenta either by compressing the uterus or, what is worse, pulling on the cord, is usually promptly followed by a uterine contraction that

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closes the blood vessels, yet the saving of time is at too much risk of leaving the vessels open. After the placenta is delivered the uterus should be watched and firm contraction insured by stimulating it on the slightest sign of relaxation by cold or rubbing. This is of value to prevent post-partum hemorrhage, and it will be appreciated by your patient as a preventative of after-pains. If, after twenty minutes to half an hour, the uterus remains well contracted and the pulse has diminished naturally in frequency, then, and not until then, may the patient be left. Of course, such accidental causes of post-partum hemorrhage as ruptured varicose veins in the vagina, lacerated cervix and the like need not be considered, though it is well to bear in mind that a full bladder may interfere with the contraction of the uterus after, as well as before, labor is completed.

In all the records to which I have had access, of autopsies performed on women dying of puerperal eclampsia, kidney lesions have been found. If puerperal eclampsia has occurred without some previous symptoms of renal incompetence, it must have been very rarely. Albuminuria, abnormally low specific gravity, with or without a diminished secretion of urine, are the principal symptoms referable to the urine. Albuminuria may be transient or, I think very likely, absent as it frequently is in some of the chronic forms of Bright's disease. Of the other symptoms of renal incompetence the prominent are vomiting, oedema, headache, disordered vision, vertigo, restlessness, sleeplessness, weariness and mental disorders, especially mania. Any one of these should lead to a careful consideration of the patient's condition. I have learned by experience that a severe trace of albumin, even with some oedema of the feet and legs, may be disregarded. I have also learned that a considerable amount of albumin, even though the patient shows no other sign of illness and is in the best of spirits, it is a danger signal *not* to be disregarded. It is the duty of every one of us to examine the urine of those whom we expect to attend in confinement, with sufficient frequency to be certain that the urine is normal, and to request the patient or some member of the family to report at once the occurrence of any of the symptoms enunciated above.

Omitting any theories, it is without doubt the existence of pregnancy that determines the kidney lesion, and after delivery in the majority of cases, the kidneys regain their functions. It is a recognized fact too, that the most important factor in the successful treatment of the convulsions, when they do occur, is the emptying of the uterus. It follows from these two propositions that the most successful preventative treatment of puerperal eclampsia lies in abortion or premature delivery.

The child's existence, however, must be taken into consideration, and abortion or premature delivery must be recommended with some qualification. If the child is viable you have no more right to subject the mother to the risks of convulsions or irrecoverable renal disease by allowing the pregnancy to continue, than you have to subject the child to the risks of being prematurely born. If, however, the child has not reached a viable age, then an abortion should or should not be performed, according to the length of time pregnancy has already existed. If the child has already arrived nearly to a viable age, i. e., if pregnancy has existed six and a-half or seven months, attempts should be made to carry the mother successfully along by means of diaphoretics, diuretics, cathartics and tonics until the child is viable, when premature delivery should be accomplished. If, however, renal disease is discovered during the early months of pregnancy, any attempt to continue the pregnancy can result only in disaster. If convulsions do not occur, a disease which cannot be recovered from is the result. Fortunately nature solves the difficulty in the majority of cases by a spontaneous miscarriage, and we should follow her limits by inducing abortion under the same circumstances.

The last class of cases considered covers, of course, those in which pregnancy supervenes on pre-existing Bright's disease. Although hardly within the province of this paper after what I have written, I cannot but add that premature labor should not be induced without preparing the patient for it by free watery catharsis, lest we should bring about the convulsions we wish to avoid.

The greatest number of deaths occurring in child-birth are from puerperal fever, and yet these above all others, are with most certainty prevented. Puer-

peral fever is every time sepsis and prevention is asepsis. This is not *probably* so, it is a positive fact. It is not uncommon to hear practitioners, after years of experience in midwifery, claim with a boastfulness that is truly childlike, that they have never used antiseptics in child-birth and yet have never had a case of child-bed fever. So do some thieves escape the police for years. But unlike the doctor the thief takes the chances himself. That I have a right to make this assertion in regard to aseptic midwifery as strong as I have, is shown by the report of the Boston Lying-in Hospital for 1891. Out of 1270 women delivered, there were but four deaths. One of these deaths was from cancer; one from phthisis; a third out of the four from scarlet fever, and in all death took place after a safe delivery. The fourth death was from the vomiting of pregnancy, and the exhaustion was so extreme when the patient was brought to the hospital that nothing could be done to save her life. If we except this last, as we must, there was not one death out of the 1270 women attended, that was attributable to child-birth. And this in a hospital where, before our knowledge of the nature of a sepsis, it was dangerous for a patient to be confined. During my own term of service as house-officer in 1879, when we washed our hands *after* an examination and not before it, and lubricated the examining finger with vaseline from the same jar that was moved from one patient to another as required, out of ninety-eight women delivered, five died and eleven had puerperal fever. What a showing that is by the side of the report from the same hospital for 1891.

My own practice now is, in the first place, to make as few examinations as possible; most of the diagnosis is made from external palpation, the length of time labor has been in progress, and the character of the pains. It has been advocated even to omit vaginal examinations altogether unless interference is probably necessary. Before the patient is approached, the hands and arms are thoroughly washed in soap and water and scrubbed over and over again with a nail brush. Then they are scrubbed over and over again in a 1-1000 solution of corrosive sublimate. The patient's genitals are carefully washed by the nurse. Any instrument to be used is sterilized in boiling

water and kept in a solution of carbolic acid. Hands and instruments are lubricated with "bichloride soap" rendered soluble by a 1-1000th corrosive sublimate solution.

Of the after-treatment I can only say it is carried on as strictly as possible in the same lines of a sepsis. I believe that it is a result of this care that I rarely see "milk fever," and have never, so far, to regret the occurrence of a case of child-bed fever, either in my private or hospital practice. This paper is not intended to be explanative, and, of course, it covers only what everybody knows, but the number of deaths from child-birth in Rhode Island, which have been acknowledged to be due to preventable causes, shows very plainly, that greater care might,—in fact, should,—be taken.

The Armour Institute.

The erection of this building by Mr. Philip D. Armour has been going on for a year, but the purpose of the building was kept "dark" until Mr. Armour left for Europe recently. He gives this building and an endowment of \$1,400,000, but that does not include the fittings, which are to be put in at Mr. Armour's expense. The building is one of five floors. On the second are the chemical laboratory, the chemical lecture room, the physical laboratory, the physical apparatus room, the physical lecture room, and electrical rooms. The third floor will be used by students in freehand drawing, mechanical and architectural drawing, and in commerce and business.

The fourth floor is devoted to the domestic sciences, there being departments of cooking, dressmaking, millinery, and kindred studies. At one end of the fifth floor are the gymnasium and technical museum. The faculty of the institute will be of the highest standing, and it is Mr. Armour's desire that students may have opportunities to be prepared for the higher universities, or practical work in any field or mechanical or scientific labor. Every possible convenience for scientific research and experiments will be provided. The institute is not located in a fashionable portion of the city, and Mr. Armour's idea in placing it where he has, is said to be to put the institute among those whom it will most benefit.—*Ex.*

CLINICAL LECTURES.

SARCOMA: ARTHRITIS DEFORMANS: CICATRIX FOLLOWING BURN: MORBUS COXARIUS.*

ROSWELL PARK, A. M., M. D.

SARCOMA.

This patient is a man, aged thirty-one, who presents a tumor in the region of the groin. Four weeks ago he received a blow in this place from a barrel. Previously he was perfectly well and was not aware of any swelling in the groin until after the injury.

The inguinal tumor is evidently composed of lymph nodes and we might jump to the conclusion that we have here buboes, and begin to search for evidences of past or present venereal disease. But of this we get neither indication nor history. The next hypothesis would, perhaps, be of tubercular involvement of the nodes. But there is nothing to verify this diagnosis. We have to differentiate, I think, between tubercular and malignant disease. There is a history of injury which has a little bearing on the case, but not very much since malignant disease is known to develop rapidly after an injury, and it has been known to occur with just the same rapidity without any traumatism. It is possible to have a tubercular infection also following an injury. To aid in the diagnosis I call your attention now to another feature, namely, a large mass in the pelvis above Poupart's ligament and dipping down into the iliac fossa. Yesterday, on rectal examination, it was easy to make out a mass with which I could get almost a ballottement. Considering the presence of the large mass in the pelvis with the external lymphatic swelling, the diagnosis becomes almost certain that we have to deal with a malignant condition, and probably a sarcoma. Of course, it might be a carcinoma, but this mass, so far as I can learn, arose in tissues which are not supposed to have epithelium, and the patient is rather too young for carcinoma.

The patient has not suffered much pain; he has failed quite rapidly; there has

been no temperature development such as would be expected with tuberculosis, and so, partly from the absence of that which we would look for in tubercular trouble, and partly from the presence of the large pelvic mass, which is larger than I have ever seen develop in the same length of time from tubercular infection, I have come to the diagnosis of sarcoma of the lymph-nodes and the lymph channels extending from the groin up into the pelvis.

The mass extends too deeply into the pelvis to justify any attempt at extirpation. If the trouble is going on as rapidly as the patient thinks, there must certainly be lymphatic involvement above the point at which I can detect it from the outside. While it would be perfectly possible to remove the mass in the groin and even to separate a large portion of the internal tumor, I should feel certain that I was leaving *in situ* the seeds of fresh trouble, and so I should not advise operation in this case.

I should advise the experimental use of arsenic iodide in doses as large as can be tolerated, commencing with four milligrams three times a day; then giving four doses a day and increasing the dose as much as possible. Or one may give Donovan's solution of the iodide of mercury with the iodide of arsenic. We should commence with doses of twenty drops three times daily, to be pushed to the physiological limit. I think it is certainly true that arsenic influences cell growth, and there are cases in the experience of every surgeon, of neoplasms whose growth has been rendered slower or checked by the internal administration of the drug. But I should regard it as miraculous if this case were cured—provided I am right in the diagnosis of sarcoma. All that I hope to do, therefore, is to check the growth of the tumor, cause the subsidence of a distressing symptom and prolong the patient's life.

*Buffalo General Hospital Surgical Clinic. Reported by A. L. Benedict, A. M., M. D.

ARTHRITIS DEFORMANS.

This patient is a man of fifty, who presents a very curious condition of the knee-joint. I shall not attempt to give you an exact diagnosis previous to the operation. I first saw him two years ago, a fact which I had forgotten till reminded by the patient. About eleven years ago he fell from a load of hay, striking with this leg and joint upon a pole which lay on the ground. In some way the joint was seriously injured. He has been lame and partially disabled ever since. The joint has been swollen and in its present condition for about two years. He says it is over two years since he himself noticed inside the knee-joint a movable body, not one of the little masses of detached cartilage which the Germans call "joint mice," but a good-sized body. There is certainly something of the kind in the joint cavity, as nearly as we can judge from the external sensations. There is a large amount of distension of the synovial sac; there is alteration in the shape of the bones, especially the upper end of the tibia, and there is more or less bony outgrowth from the margin of the head of the tibia. The knee is growing slowly worse instead of better, and I have advised the patient to have at least an exploratory operation performed, and then, if anything calls for further interference, to allow me to meet the indication.

Around many joints, as the result of injury, or even of the uric acid diathesis there are formed masses of new tissue, and alterations occur in their contour with the growth of exostoses so that the original appearance of the joint becomes totally changed. To these conditions in general has been applied the term *arthritis* (or *osteitis*) *deformans*, and, undoubtedly, in this case we have to deal with something of this character. The operation has for its purpose a better acquaintance with the internal conditions; the removal of whatever diseased or deformed tissue can be removed, and the improvement of the function of the joint. Incidentally we must try not to make matters worse than they are at present.

He has had just the preparation which every case of any importance has in my clinic. The area of operation is shaved and cleaned, a green-soap poultice is applied and the part enveloped in an antiseptic dressing for twenty-four hours

before the operation. The knee is now scrubbed with a bichloride solution, and the adjoining parts are covered with towels moistened in the same solution. The hands of all of us who come in contact with the field of operation or the instruments and dressings, are thoroughly cleansed with soap and water, care being taken to keep the nails short and to brush vigorously around and under them.

We now add antiseptics to apparent cleanliness by dipping the hands into a potassium permanganate solution. Those of you who are near can smell the ozone which arises, and you can all see how the organic matter is blackened. The hands are then bleached in a solution of oxalic acid and hyposulphite of sodium.

When the knee is drawn up you notice the irregular bosselated appearance, some of the swelling being fluctuating and consisting of the distended joint-capsule, the rest being a bony outgrowth. Above the margin of the head of the tibia I feel a hard mass, and above this a movable body of whose adhesions to other tissues I can form no idea until it is exposed. The slow growth seems to be more of the nature of an exostosis than of a true osteoma. Malignancy, I think, we can exclude altogether. In exostosis there is some feeble suggestion of physiological function, a mark of distinction from an osteoma.

On making a longitudinal incision at the inner border of the patella I come upon the movable mass to which allusion has been made. It is very closely adherent to the surrounding tissues and I will dissect it out with the scissors while an assistant holds it with the tenaculum. The tissues about the joint are enormously thickened and I doubt if I have even yet entered the joint cavity proper. Above this mass I feel something large and hard, which proves to be the enlarged condyle of the femur. As I manipulate the leg you observe that there is considerable lateral play permitted by the disorganization of the ligaments. The external lateral ligament is particularly weak, for bringing the leg inward and then suddenly outward, there is a hammering sound as the bone surfaces come together. This is entirely abnormal, and must be due to the relaxation of the outer lateral support. I do not feel that any further interference is necessary after removing this mass and

trimming away some of the newly formed tissue. I will, therefore, close up the cavity that I have opened. There are no dead spaces left to require drainage. I am using the subcutaneous suture which leaves no cross-marks and makes only a linear scar. After applying the antiseptic dressing a well-padded posterior splint is bound on the limb and, later, the leg will be done up in plaster-of-Paris in order to give it prolonged rest.

CICATRIX FOLLOWING BURN.

This patient affords one of the best possible illustrations of the evil results of vicious cicatrization following a burn. About fifteen months ago he was burned about the face and arms by a coal-oil explosion. The burn was of the second degree, according to the simpler classification into three degrees which I think is preferable. The old French writers used to give a classification into seven degrees, which is almost like the seven degrees of grace, rather indefinite and hard to outline. Three degrees may be very clearly defined—(1) When the epidermis alone is burned; (2) When the epidermis is burned through to the subcutaneous tissue; (3) When the burn is very much more extensive.

Burns leave enormous surfaces which have to heal by a process of granulation and cicatrization, except that where little islets of epithelium are left undisturbed the cells may proliferate and help form a covering something like a true skin, but destitute of sudoriferous glands and hair follicles. When the epithelium has been entirely destroyed we can hope for nothing more than a cicatricial covering. As I have had to remind you often, the result of the inevitable contraction of cicatricial tissue is to produce more or less deformity. The very worst illustration of this which I ever encountered was in a boy who was brought to this clinic three years ago with a very extensive burn of the front of the neck which was almost dislocated by the drawing of the cicatricial tissue. Relative to the condition when I first saw him, the boy made a good recovery after a most extensive operation.

This case is not so bad, but there are cicatrices of the anterior region of the neck which draw the chin down. The same contraction has drawn down both shoulders so that one arm can scarcely be lifted from the side. The patient seeks relief

and he has been told that the operation consists in substituting one scar for another, but allowing the more annoying cicatricial tissue to be cut away. I shall try to raise flaps of normal skin from contiguous regions and transplant them to the affected regions, leaving hinges to insure their blood-supply. This is a kind of plastic work which has often to be resorted to in cases of this sort. Two weeks ago we had here a case of a young woman who was also burned by coal-oil in about the same way as this patient. She had along the border of the jaw a very thick keloid scar which she considered a very serious disfigurement and which she wished to have removed. I accordingly dissected it out and put up a flap from the neck to cover the raw surface.

The scars here are not only bands of fibrous tissue but they have a livid red appearance and an irregularly raised or "napped" appearance which entitles them to be considered as in some degree keloid. Keloid is a peculiar kind of fibrous tissue which is stimulated to grow especially after such accidents as burns. Keloid tumors do occur spontaneously, as large hyperplastic growths of the fibrous tissue of the skin, quite similar to fibroids or even some fibro-sarcomata. The structure is not exactly the same, although it is similar. Such tissue as you see here is quite different from the smooth cicatrix which forms after the healing of ulcers. The tendency to the formation of keloid tissue is something that cannot be prevented. The more you cauterize it and try to keep it down, the more you will provoke its growth.

What annoys this man particularly is the presence of one or two strips of keloid tissue on the neck which bridle down the head. I shall remove these and substitute, as well as I can, skin flaps from the surrounding parts. In a case of this kind, it is well not to raise the patient's expectations too high. The cosmetic effect will not be ideal under the best of circumstances. Fortunately, this patient does not care about that element in the treatment. He wishes to be relieved of the limitation of movement caused by the keloid scars.

MORBUS COXARIUS.

As this boy sits on the table you notice the apparent shortening of the left leg. As he stands you will observe that he

stands on his toes and there is great displacement at the hip; as he lies on his back, with the knees raised and the thighs flexed on the trunk, when I attempt to bring his knee to the table the back is raised. There is a teetering, so to speak, of the knee and back, owing to the spasm of the psoas muscle which prevents motion at the hip. There is marked adduction, and in the endeavor to make the normal leg parallel with the adducted one, his body is drawn to one side. The adduction is due to spasm of the adductor muscles. I can hardly make any motion of the thigh without moving the pelvis. We can make out the actual shortening in one of two ways; either by measuring from the anterior spinous process of the ileum to the internal malleolus, or by bringing his knees up when, if the pelvis is horizontal, any shortening will be evident by the knee of the affected side being lower than the other. In this case the actual shortening is slight, the marked difference in the two legs being due to the adduction of the affected one. I can illustrate this to you by sitting before you with my feet drawn upon the round of the stool. While my body is at right angles to you and my feet pointing directly toward you, the knees are in the same plane parallel to the lateral plane of the body. But if I turn slightly, by adducting one thigh and abducting the other, then the knee of the adducted leg appears nearer the body and there is apparent shortening of that extremity.

There is no question but that this is a case of hip-joint disease in the second stage. The boy's parents are very poor and have not the means for buying an apparatus. I think it *might* be possible in such a case, given time and money and careful supervision, to treat the disease apparently successfully without operation. There being no sign of suppuration yet, although there must be a focus in the bone somewhere to produce the reflex symptoms, I believe that by first keeping the child in bed with weight and pulley applied to reduce the muscular spasm, and then by nourishing him freely and getting him out doors with a splint to keep the leg motionless, we could probably effect a cure by ankylosis. This would require at least a year's time and would entail a relatively great expense for a poor man, for the splint alone would cost at least thirty-

five dollars. It would be a pity to start such a line of treatment and then find that the parents could not persist in it. Under the circumstances, therefore, I should recommend resection as being the quickest and cheapest means of cure, and I would not be averse to it at any time though now it is expedient rather than necessary. Ten years from now I believe the boy will be better off with the resected joint than he would be with the ankylosed hip-joint which could be obtained from the costly rest treatment. The upper end of the bone is not now enlarged, or I should recommend resection without regard to the features alluded to above. In fact, on general principles I believe that the results of exsection approach nearer to the ideal desideration than can be obtained in any other way, save in certain very favorable cases which are seen very early by competent men.

Dislocations.

Never attempt to reduce a dislocation of the humerus in an old person without first examining the state of the arteries to inspire you with caution and gentleness.

Never put a *booted* foot in the axilla to reduce a dislocation.

Always reduce by some other method if the rib are broken on the same side.

Remember that injuries to the elbow joint are often very difficult to diagnose, if much swelling co-exists; but:

Never give a positive opinion of an elbow joint until you have carefully examined the relations of the olecranon, internal and external condyles, and head of radius.

Remember that in dislocation at the elbow the joint becomes rapidly irreducible.

Never forget that a faulty diagnosis may cause loss of motion in the joint.

Never be ashamed to say you "do not know" until the swelling has subsided, and you are able to be certain of the character of the injury.

Do not forget that in dislocation of the carpal bones that the great point is to see that the motions of the fingers are early restored.—*Med. Era.*

Homeopathic.—Gwendolyn Eeversleigh laid her throbbing brow against the pane. She was a believer in homeopathy. Pane vs. pain!

COMMUNICATIONS.

CARDIAC STIMULATION IN PNEUMONIA*

JOHN A. LARRABEE, M. D., LOUISVILLE, KY.

Pneumonia has probably been the subject of more medical literature than any other disease. When I graduated in medicine, I am quite certain that, of thirty-five thesis required of candidates for graduation, pneumonia constituted the subject for about twenty-five. I well remember the compliment paid me by the Faculty because I had chosen some other subject. I wrote my thesis for graduation on the subject "Hospital Gangrene," and I have many times thought what a relief it must have been to that dignified body—most of whom are numbered with the angelic doctors—to have a change of subject. I may add with pardonable pride that my thesis was made the subject of special mention.

Those puerile compositions were a tolerably fair reflection of the medical teachings of those days in which *idiopathic* inflammation was an acceptable term when illustrated by the stages "Calor," "Dolor," "Rubor" et "Tumor." It is also true that there is no disease that more clearly marks the progress made in scientific medicine for the last twenty-five years, than this same trite subject, pneumonia. The auscultatory signs, the percussion note, the transmitted resonance, the hepatization and the stage of resolution were necessary to the elucidation of the phenomena supposed to be produced by a "bad cold." Cheesy deposits, the unabsorbed products of inflammation, were but different stages in the development of tubercle and the cause of the rapid consumption.

How little did we then dream that behind all this patient pathological study in which we have all craned our necks in the "dead house;" that, underneath all this crude tubercle and cheesy deposit there existed a wonderful world teeming with microscopic life, the light of which should make plain the darkness of that pathology.

Before the wonderful discoveries of Friedlander I thought the crisis of pneu-

monia was to me a most unaccountable phenomena, in that, without any visible improvement in the consolidated lung we should have as sudden an assurance of recovery as we had of its invasion. The discovery of the pneumococcus and its pneumotoxin as the indisputable cause of the disease, and the anti-pneumotoxin which produces the cure, are stepping stones upon the boundary of a great natural law.

Those of us who may be permitted to live another decade will see the benefits arising from this discovery, and will be able to arrest the progress of acute infectious diseases by injecting the products of the disease taken from convalescents.

The two grand divisions of pneumonia which differ none the less widely in etiology than in the mode of termination, will always be taught. The catarrhal form, which after all is only an ultimate bronchitis, the type of which is seen in infancy and as a complication in many of the exanthemata, will not enter into this discussion. It will be understood, therefore, that whatever may be said concerning cardiac stimulation concerns the so-called croupous pneumonia only.

In all this time, regardless of the change of views as to etiology and pathology, men, women and children have been dying from pneumonia in no less numbers. In all this time, the mode of the approach of death has remained the same under any and all treatment, coming through the right heart—a distended right ventricle, a stasis in the pulmonary circulation and a corresponding emptiness of the arterial current.

It may be truly said that therapeutics follows the advance of medicine just as the coal cart follows the engine—always a reasonable distance behind. Just here I ask your indulgence for a moment while I quote some statistics from the most excellent paper of Dr. J. T. Jelks, of Hot Springs, Ark., who also quotes them from Dr. Townsend Coleridge and Dr. Wells' report of "Mortality of Pneumonic Fever."

*Read before the Medico-Chirurgical Society, Feb. 3, 1893.

These statistics are entitled to our consideration on account of the care with which they have been collected and from the acknowledged truthfulness of the author. From the first of these reports it appears that 1,000 cases of pneumonia were treated in the Massachusetts General Hospital between the years 1822 and 1890 inclusive. The average mortality was twenty-five per cent. From 1822 to 1832 the mortality was only ten per cent. In the latter report, the number of cases tabulated was 233,000, and these statistics include the various hospitals of America and Europe, and embrace the time between 1800 and 1890. The average mortality was 18½ per cent.

Now in the first period of this time it cannot be doubted that the treatment was heroic in the fullest sense of that term as it applies to blood-letting, calomel and tartar emetic, for this treatment marked the first half of the nineteenth century. Now to make another division of the same report, the mortality in the last ten years has been twenty-eight per cent., and this must have included many cases treated upon the expectant plan advocated by Dr. James Hughes Bennett.

How then are we to harmonize the results obtained under a treatment long since condemned by common consent of the profession, with the results of the treatment of to-day under the broad light of modern pathology; in other words, the ten per cent. mortality in the decade between 1822 and 1832 with the twenty-eight per cent. mortality between 1880 and 1890. Were those Sangrado bleedings and those terribly depressing agents less active upon a stronger population, or did they, in spite of the evils which they could not fail to produce, strike at some underlying principle in therapeutics which we, with all our modern accomplishments, fail to recognize. I am disposed to the latter conclusion. Notwithstanding they come to us like a sound from the ringing rocks of past ages, there is to-day much truth in the statement that blood-letting is indicated in pneumonia. The period for its employment is at the time when the right heart is over-distended and is about to cease the performance of its function. More blood is coming into the right auricle than can be forced through the obstructed lung, and the ventricle is fagged out in the futile attempt to fill the left

heart. The right ventricle is so distended at this time that the apex beat is completely removed from its original site in the inter-space between the fifth and sixth rib, and the ear detects a dull muffled sound, and percussion reveals an increased area of dullness. All this occurs at a time when the ptomaines from the vegetable pneumococcus are being absorbed into the circulation, and before the anti-pneumotoxin has been formed in the albumen of the blood. Experiments in vivisection have demonstrated that a heart brought to a stand still in such a diastole, may be revived by aspiration of the right ventricle.

The question may then be properly asked, where does the application of cardiac stimulation come in this condition? Is it philosophical to attempt the relief by a *vis-a-tergo*, or is it more rational to attempt the relief by a *vis-a-frontis*? Are these the indications for the employment of digitalis? It may be a good plan to goad the tired ox that has fallen in the furrow if you want a little more work. But you will have a little less ox. It may be good therapeutics to stimulate a diseased kidney with irritant diuretics if you want just a little more urine and a little less patient. And it may be good practice to give digitalis to a fagged out heart in the stage of hepatization in croupous pneumonia. But I doubt it. Digitalis stimulates a weak heart by contracting the arteries and arterioles, throwing the blood back upon the heart itself, and, where there is no pulmonary obstruction, the action is prompt and efficient. But the very condition which is killing the patient in pneumonia would be rendered still more dangerous by such an agent. It has been found that even ligation of the lower extremities just sufficient to prevent the return of venous blood, is followed by relief to the heart. The sense of relief felt by the patient upon the application of a hot flax-seed poultice, is in a large measure due to the dilatation of the blood vessels of the chest walls. Pediluvia also would prove of great service were it not for the ever present danger of assuming the erect position. Alcohol will prove a far better cardiac stimulant in pneumonia by reason of its power to dilate the capillaries, thereby retaining more blood in the skin, while at the same time it may have some value as a respiratory food. Nitro-

glycerine and the nitrites may be expected to rescue a heart after the manner of aspiration, and theoretically, would prove to be cardiac stimulants in the condition under consideration. I understand also that they have been of practical benefit. Cuppings, either with dry or wet cups, over the region of the inflamed lung have also been productive of relief. Very warm baths give almost immediate relief but are difficult of administration to adults. They are available in childhood.

It should be remembered that at one time *veratrum viride* and *aconite* superseded blood-letting. These agents, long considered identical in action, have nothing in common. The former does not

weaken the muscular power of the heart and may have a place as a cardiac stimulant in pneumonia, while the latter is a highly dangerous drug capable, even in moderate doses, of paralyzing the centers of *Steichenow* in the heart. *Strophanthus* is a far more effectual and safer remedy in the condition under consideration than is *digitalis*. *Strophanthus* acts upon the ganglionic motor centers in the heart, leaving the arterial tension alone. Caffeine is a cardiac stimulant by no means to be despised in pneumonia. The value of a cup of strong tea or coffee has been long recognized in domestic practice. Very small doses of strychnine may also be of advantage.

ASEPSIS IN OBSTETRICS.*

DR. M. R. MITCHELL, TOPEKA, KAN.†

Asepsis, as a comprehensive term, is applicable to three different fields in the struggle against the septic germ, viz: Prevention by cleanliness, by the removal or avoidance of such conditions as may cause putrescence or septicæmia; second, by correcting or counteracting septic infection already existing—antiseptics; third, by destruction of the septic germ—germicides.

The advantages of thorough aseptic management applied in the fullest sense in general surgery are to-day acknowledged by every one worthy of the name of surgeon. In fact the faith has become so strong and the practice so common, that the surgeon not using it is liable for mal-practice in case of bad results.

The principles of asepsis are as scientifically applicable to obstetric practice.

The prevention of puerperal sepsis is the all important phase of the subject, and it is this that I desire particularly to emphasize in this brief discussion.

The application of prophylactic precision can nowhere have a more useful place than the lying-in chamber. True it is that occasionally a case of puerperal sepsis cannot be cured, but very seldom is it true that it could not have been prevented.

As I turn my attention to this subject I rejoice and take courage at the thought that it has become of late days a topic of absorbing interest. It is being discussed by medical minds in cities, towns and rural districts with a great degree of practical intelligence and enthusiasm.

The croaker, crying out against all this as meddling midwifery, will soon be found only in the past.

Much responsibility is imposed upon the obstetrician of to-day. He is forced to contest the field with the abdominal surgeon for a record of the greater number of cases without a death. The country family physician is now set to thinking how he may compete with the city accoucheur applying his aseptic methods while on his rounds of work along the thickly populated alleys, byways and highways. Yes, and he finds, too, that he must improve his record in order to share honors with the maternity physician whose germ-laden hospital wards a few years ago were the slaughter pens of a large percentage of lying-in women.

The records of the New York Maternity on Blackwell's Island, or the Boston Lying-in Hospital, only a decade ago showed a death rate of from four to fifteen per cent.

But, after the introduction into these institutions of aseptic care, there was a speedy diminution of fatality. As these

*Read before the Western Obstetrical and Gynecological Association.

†Professor Obstetrics Kansas Medical College.

methods have been gradually developed and simplified to a high degree of accuracy and preciseness in all the minutiae, to-day's record will show a series of five hundred labors or more without a death.

In the Transactions of the Obstetrical Society, of Philadelphia, of last January, it was reported that, at the Preston Retreat, there had been one thousand cases of labor without a death. And this report comes to us as the result of the skillful direction of none other than America's most successful abdominal surgeon and obstetrician, Dr. Joseph Price.

This institution is a model in all of the varied details of purity and cleanliness as well as of antiseptics.

Why this great gain in the saving of the life of parturient women?

What are some of the conditions attending the lying-in process which make it necessary to use such precautions in order to guard against puerperal sepsis? Although the phenomena of normal labor are physiological, yet there are pathological changes of a greater or less extent in every case of labor, normal or abnormal; and, as Dr. Price expresses it, "A woman during and after labor is a wounded woman."

In every child-birth there is, in addition to the utero-placental attachment, more or less contusion or laceration in some part of the birth canal. It may be the cervix, the vaginal wall, or the vaginal orifice. However insignificant such a lesion, it affords a possible entrance for septic infection—a disordered state which, in the words of Prof. E. P. Davis, of Philadelphia, "is identical with septic infection occurring in any recently wounded patient, whether it be a man crushed by machinery, whose wounds become infected during handling by the careless surgeon, or a woman whose torn perineum is infected during labor by the unclean fingers of her attendants." Again there is a greater or less depression of the nervous system, a lassitude and lowering of vitality which leaves the woman less able to resist septic influences.

As to precautionary measures in these cases I cannot enter into any detailed description, but will simply allude to a few leading points of procedure.

In a general way the patient should be surrounded with such environments that the dangers of infection may be reduced

to a minimum, and the process of absorption and repair may be interfered with as little as possible, but encouraged in every way.

Proper attention is requisite before, during and after labor.

Before labor, there should be preparation of the patient by thorough bathing, and she should be furnished with clean clothing, clean bed, clean and well aired apartment. Labor begun, the rectum and bladder should be evacuated. The external genitals thoroughly washed with soap and water, and then bathed in an antiseptic solution such as 1 to 2,000 of bichloride of mercury.

The vagina should be douched with the same solution, or with a solution of creoline, hydronaphthol or carbolic acid. There should be but little manipulation of the vulva and vagina, and only with hands rendered thoroughly aseptic. All instruments and vessels used about the patient should be cleansed with carbolic acid and boiling water.

Following normal labor, the vaginal canal should be douched once with a solution as before labor. The external genitals should be cleaned and bathed with the bichloride solution, antiseptic gauze with a pad of folded napkin, or better, of absorbent cotton, applied. The vulva should be thus cleaned and dressed every four to eight hours until the cessation of the lochial discharge.

Throughout the puerperal period any evidences of septic infection from decomposition of lochia, blood-clots, or membranes should be promptly met by antiseptic vaginal douches, and even intra-uterine, if that organ is involved. If the bichloride solution is used, it should be of the strength of 1—5000, followed by douche of boiled water.

Dr. E. E. Montgomery suggests iodoform gauze rope introduced intra-uterine for drainage in these cases.

Another essential procedure is to shut the doors of entrance for sepsis, viz.: the veins, lymphatics and fallopian tubes, by promoting uterine contractions and aiding other physiological processes of restoration.

The course of puerperal sepsis can be readily apprehended when we recall the anatomy of the lymphatics in the vicinity of the genital tract. And remembering the ready access of infecting germs through

these channels in freshly made wounds, we can realize the speedy involvement of the numerous glandular structures in the vicinity of the pelvis, extending possibly to the uterus, its appendages, and the peritoneum. Hence we will have such inflammatory conditions as vulvitis, vaginitis, metritis, ovaritis, salpingitis, and peritonitis.

A very important consideration in connection with this subject is the fact that the fatality from septic infection is only one of its far-reaching results. A very large number of mild cases of sepsis, and which are mostly lost sight of by the general practitioner, become in after years, the victims of wrecked health, a life of suffering and of an untimely grave.

The work of the gynecologist to-day is largely traceable to the dirty finger nails, or the personal indifference to the simple, practical and important details

of asepsis on the part of the obstetrician.

When Dr. So-and-so relates his large experience in confinements without an instance of septicæmia, and that too without the observance of the new-fangled aseptic precautions, the only rational conclusion is that the true cause of the chronic ill-health of many of his patients has not been perceived by him, and his boasted experience is practically equivalent to the confession that he is unable to recognize the presence of mild sepsis.

Since the attention of the profession has been directed to aseptic practice, the progressive tendency in technique has been to greater simplification in the details. And that is to-day the best method which affords the safest protection to the patient, and which is most easily and readily applied in the every day practice of the physician.

SOCIETY REPORTS.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, February 3rd, 1893.

The President, Dr. F. C. Simpson, in the chair.

CASE OF EXTRA-UTERINE PREGNANCY—OPERATION; RECOVERY.

DR. A. M. CARTLEDGE: I will just briefly run over the history of a case before showing the specimen. Some three weeks ago I saw a lady, 36 or 37 years of age, who was suffering with severe pain coming on suddenly in the right side of the chest, which proved to be an ordinary pleuritic attack very well marked at first, and subsequently followed by a slight effusion. After a week or so she recovered from the attack of pleurisy, was about the house, and getting along fairly well, so much so that I had not seen her for four days. I was again called to see her fourteen days ago. She was complaining of excessive pain in the right side, referred particularly to the region of the appendix. This pain was described as being very intense, having existed all night. I saw her in the morning. She displayed a well-defined tenderness right over the McBurney spot,

midway between the umbilicus and the anterior spine of the ilium. I believed that I had a case of appendicitis, but temporized for the time being. Her temperature at that time was 101° F., pulse about 100. I saw her again in the afternoon when she expressed herself as being much easier. This state of affairs continued for two or three days. About the fourth day I detected a slight lump in the right side over the region of the appendix, about the size of a duck's egg, which was very tender, but there were no evidences of general peritonitis. Pulse now about 120, temperature 102° F. I advised operation, supposing that it was a case of appendicitis. This was refused.

The case went on from day to day, the enlargement in the right side increasing all the time. I thought I could detect a well-marked fluctuation in this tumor. It was very tense and was typically in the appendicular region, reaching up above the McBurney point, and, taking everything into consideration, it seemed about as clear a case of appendicitis as I have ever

seen. Last Tuesday the patient complained of pain about the median line just above the bladder; tumor in the right side practically unchanged. I was becoming very uneasy about the case and urging operation. Wednesday morning pulse about 112, temperature 100° F. She complained about a week ago of some little shivering sensations. I told her that she must either consent to an operation or consult another physician, as she was certainly growing no better. She consented to the operation, which was performed last Wednesday. Believing that I had an abscess around the appendix, I made the usual incision over that organ, dissecting down carefully until I reached the sac. Then with a small incision about an inch in length covering the sac proper, I found there was no peritoneal adhesions in front because I could see some fresh peritoneum; in fact the abdomen was already open. It was my first intention to expose the sac, wash out the cavity thoroughly and remove the appendix which was supposed to be diseased. I then broke the very superficial adhesions in front, passed my hand around and located this tumor, about the size of an orange. I found the adhesions quite extensive, especially to the colon. I now commenced separating the adhesions leading down to what I supposed was the appendix, and in lifting up the intestines was very much surprised to find the tumor easily freed from from its superior attachments. I packed gauze around the intestines to get them out of the way thoroughly. I then drew the tumor up into the wound and found it necessary to enlarge the incision in a backward direction. In removing the tumor the sac was ruptured and was found to contain probably a pint of fluid. When this fluid ran out of the sac as the woman was lying on her side, something dropped which led me to stoop and pick it up and lay it aside. The sac was now discovered to be the right tube and ovary which were tied off and removed. The cavity was thoroughly cleansed and the patient put to bed in a very fair condition.

An examination of this specimen proves it to be unique indeed, as one of extra-uterine pregnancy occurring about as near the ovary as we will ever see; a condition that is denied as you are all very well aware, by some very eminent authorities, among them Tait, claiming that all cases

of extra-uterine pregnancy are tubular in character. I believe this is a typical case of impregnation of the ovum just as it was being released by the ovary, the artificial uterus being the ovary itself. The tube is entirely intact. I will state that there is no history of recent cessation of menstruation, and none of the usual symptoms of extra-uterine pregnancy. How old it is I do not know.

What I want to call especial attention to is to the fact that the artificial uterus is the widely separated ovary or ovarian tissue. This patient has had one child, about fourteen years ago. She has since made an uneventful recovery.

DISCUSSION.

DR. W. O. ROBERTS: I think a microscopical examination ought to be made of the specimen to determine to a certainty whether or not it is a case of extra-uterine pregnancy.

DR. J. G. CECIL: I would not be able to give a positive opinion in regard to this case from the history given; certainly the ovary is present in the specimen and the fimbriated extremity presents a cavity which may be the cavity of an abscess, a hemato-salpinx, or it may be an extra-uterine pregnancy. I think it could be very easily demonstrated by a microscopical examination. If it be extra-uterine pregnancy it should show evidences of foetal structure. However I do not think it is by any means conclusively demonstrated thus far.

DR. A. M. CARTLEDGE: It did not occur to me that there would be any difficulty in recognizing the nature of this pathological specimen microscopically, or I would have had it microscopically examined before presenting it; this, however, will be done later.

I have detailed the history very carefully, and I would like to ask the surgeons who may be inclined to the belief that it is a case of pyosalpinx, if they ever saw pyosalpinx so large as this without pelvic peritoneal adhesions. I do not see what could possibly be suggested except extra-uterine pregnancy. Even if microscopical examination reveals no evidences of a foetus I shall still think it extra-uterine pregnancy, and that the foetus has entirely passed away—has become digested.

DR. A. M. VANCE: Do I understand, Dr. Cartledge, that there was never a case of pyosalpinx without adhesions?

DR. A. M. CARTLEDGE: I have never seen a pyosalpinx one-half this size without peritoneal adhesions and do not believe it ever occurs.

Note: A subsequent microscopical examination by Dr. Vissman of the body found in the sac, reveals clearly foetal and placental structures.

Dr. John A. Larrabee presented an essay on the subject

CARDIAC STIMULATION IN PNEUMONIA.
(See page 364)

DISCUSSION.

DR. WM. BAILEY: I am inclined to believe that there is something in what Dr. Larrabee has brought before us in his paper. However, it is not entirely new. I remember the same question came up in the section on medicine in Detroit last year. It was advised instead of digitalis that we use nitro-glycerine for dilating the capillaries. Others claimed that nitro-glycerine gave no better satisfaction than digitalis. However I do believe that in very many of these cases digitalis is advisable when the conditions indicate that the heart is over-worked and it becomes necessary to contract the arterioles. Of course I can conceive how digitalis in other cases would not give relief. I should hesitate a long time before discarding a remedy so valuable as digitalis and resorting to other stimulants which do not contract the arterioles to the same extent.

DR. A. M. CARTLEDGE: What would you consider an indication in pneumonia for the administration of digitalis or any other stimulant? How long would you wait?

DR. WM. BAILEY: I believe the principal thing in the treatment of croupous pneumonia is the management of the heart. I would put the patient in the best possible condition and assist the heart by medicine if necessary, and when it became evident that the right heart was being over-distended, then I think the introduction of a cardiac stimulant imperatively demanded. I am not quite ready to admit that I can always tell when the right heart is over-distended by auscultation, percussion, change of pulse, etc., because these phenomena may not be very manifest. Certainly I think in these cases the higher the fever the greater the danger to the heart, just as it

is in every disease in which high temperature is a factor.

DR. D. T. SMITH: The conclusions as stated by Dr. Larrabee in regard to the use of digitalis are those which I have reached some time since, and I heartily indorse all he has said. My experience with this drug in pneumonia has been such that I feel justified in saying that it should be used with extreme caution.

Concerning the microbic origin of pneumonia: Notwithstanding the recent so-called discoveries and theories in this direction, I am still in extreme doubt. This is not directly in line with the subject under discussion, but I will state, in regard to the epidemic nature of pneumonia, when we see that a little change in the atmosphere from British Columbia to the Gulf coast will spread pneumonia throughout this whole territory within a time limit of two or three days, it would seem that there is something beyond the microbe to cause it.

As to the treatment of cardiac failure in pneumonia: Of course the condition of the patient, as to age, strength, etc., and the extent of the involvement indicates the danger. The portion of lung involved we have nothing to do with, other than to endeavor to secure its protection until the forces of the system can bring about resolution. I can hardly see the necessity for commencing cardiac stimulation at the beginning of an attack, as is claimed by some authorities. This treatment should be instituted only when there is evidence of failure of the heart to properly perform its functions; I do not mean the fatal failure, but when the heart fails to send the blood through the affected lung in the proper quantities to effect adequate oxygenation.

I have been in the habit of using digitalis but always in small doses. I think our aim should be in these cases to improve the general system of the patient, and as far as possible give medicines that will not disturb the digestion or appetite. A year ago I was called in consultation to see a case of grip and pneumonia in a very aged patient; I hardly thought it was a case where digitalis should be given, yet as my consultants advised its administration, I felt no harm would be done. One-twelfth of a grain of digitalin was given in twenty-four hours—one-sixtieth of a grain every four hours. Very unfavorable

symptoms developed lasting for several days. I have no doubt that owing to the condition of the patient at the time, this was too large a dose.

I believe alcohol is very valuable as a cardiac stimulant in these cases. I would also advise the use of strophanthine, which acts without contracting the arterioles. In the use of a drug which contracts the arterioles it seems to me that the heart is given a greater amount of work to perform, hence I fail to see the advantage of such treatment. Strychnine is also of service in these cases, as it acts as a steady stimulant on the heart's action and acts upon the stomach in increasing the power of digestion and desire for food. I want to emphasize the fact that I believe digitalis should be used with extreme caution.

DR. J. A. LARRABEE: In closing I would like to avail myself of the opportunity of thanking the fellows of the society for their consideration of the subject presented, and am sorry I did not hear part of the discussion. My attention was brought to this subject very pointedly

in this way: I have seen numbers of fatal cases of pneumonia in which digitalis was being administered, and was impressed with the fact that we were not getting the effect that digitalis ought to produce. Instead of increasing the force of the heart's action and having generally a good effect, the opposite was the result. Then in looking up the statistics, as stated in the paper, there is something in this point. Blood-letting, although producing so many evil results, as we grant it does, evidently strikes the all important point in the treatment of pneumonia, as is shown by the statistics between 1822 and 1832—the mortality being but ten per cent. I became convinced, as Dr. Smith has said at the bedside, that digitalis did not and will not produce the good effects claimed for it. It is like introducing ergot into a full bladder to expel the urine instead of using a catheter to draw it out.

The point made by Dr. Bailey is one of considerable importance, especially in croupous pneumonia. The greater the pulse and the higher the temperature, the greater is the danger from digitalis.

THE WESTERN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

Annual Meeting: Kansas City, Missouri, December 27th, 1892.

[OFFICIAL REPORT.]

MORNING SESSION.

Transaction of business was followed by the annual address and the presentation of papers.

Dr. M. B. Ward, Topeka, Kan., delivered the

PRESIDENT'S ADDRESS.

Fellows of the Western Association of Obstetricians and Gynecologists:

We are convened to formally inaugurate the Western Association of Obstetricians and Gynecologists and to enjoy the mental feast, rare in quality and sumptuous in quantity, which we are assured is in store for us.

As an association, we are yet in the stage of lactation. One year ago a meeting was held in Topeka for the purpose of organizing this association, which was

attended by only a few of the number who had expressed their desire to aid in forming and maintaining such a society. Those present were enthusiastic regarding the propriety and necessity of such a society in the West.

An organization was consummated, bringing into existence the Western Association of Obstetricians and Gynecologists.

The parturition was normal; no instruments were employed; no rupture occurred to mar the perfect symmetry of the accouchement.

No programme having been prepared, nothing remained to be done with the fledgling but to wrap it in the mantle of time, and place it in the arms of our genial secretary, Dr. T. J. Beattie, who has so tenderly and wisely cared for it during the first year of its existence, that

we are enabled to celebrate with delight its first birthday, on this occasion.

I most heartily appreciate the honor of being the first president of an association whose inauguration is so auspicious and whose permanency is assured.

It is usually expected that the presiding officer will deliver, sometime during the session, an inaugural address, and it was my purpose to have carried out the established custom. But owing to a recent long and serious illness, from which I am not yet fully recovered, it has been impossible to suitably prepare such an address. I, therefore, beg your kind indulgence while I make a brief retrospect of the original plan of the organization, and a prospective view of the possibilities of the association.

Perhaps it was in accordance with the eternal fitness of things that a Kansan was prompted to take the initiative in organizing this society.

In making this reference which is intended to give Kansas credit for inaugurating many important movements that have given her a record of which all lovers of liberty are justly proud, I do not wish it to be understood that I am unmindful of the deplorable fact that, of recent, she has led in schemes whose very foundations have been carious, and the results unworthy the fair name of Kansas.

The western states are attracting universal attention on account of their wonderful resources and the prominent part they are taking concerning all great and important questions.

In no other direction are we so weak and insignificant as in the position occupied by the medical and surgical profession, as compared with the eastern states.

The East may be justly termed our Fatherland so far as concerns our profession, and we are obliged to confess that that section is entirely worthy of the honorable title.

It is to the distant East that each and all must journey if we are to gather the ripest, juiciest and richest fruit pertaining to our professional progress.

How favored, indeed, are those who are so situated that they may frequently wend their way towards this Mecca of medical and surgical knowledge.

After several visits to the East, it occurred to me that the West should at once

organize a society whose aim would be to educate those whose relations and circumstances prevent frequent visits to the more favored portion of the Union, and at the same time aid in diffusing the leaven throughout the whole loaf, which comprises thousands of struggling physicians who cannot enjoy the advantages of the far-distant metropolis.

In the early fall of 1891 a circular letter was sent to about fifty prominent physicians, who were practicing obstetrics and gynecology to the more or less exclusion of the other fields of medicine and surgery, and who reside in the states of Missouri, Iowa, Nebraska, Colorado, Kansas, and the territory of New Mexico, soliciting their opinions regarding the advisability of forming a society in the West, whose special aim should be to advance the science of obstetrics and gynecology, and whose active members should be those only whose practice is limited to these special branches, or who desired to give special attention to these branches of the practice.

Favorable reply was received from nearly every physician addressed, and a meeting to complete the organization was held in Topeka, the last days of December, one year ago.

The growth and usefulness of this organization are now assured, if the present status is a correct index of the future.

Our society should be a practical educator, sowing the seed of modern pathology and therapy in good soil, which will increase one hundred fold; in shallow soil that may not yield more than fifty fold, and, if necessary, on stony soil which may not for the present show any signs of increase, but some of the good seed may find nutrition sufficient to make a sapling whose influence will tell for truth sooner or later.

Oftentimes is it true that the dullest lad makes the most brilliant man.

Let us not despise the day of small things, though we are few in number and yet unrecognized by the medical and surgical world.

I am not certain that the plan which has been formulated for the government of our society is sufficiently broad-gauged.

In this connection I heartily recommend that a committee be appointed who shall consider this feature of the organization and suggest any change in our laws

that they may conclude will tend to increase the scope and usefulness of the society.

We should endeavor to make the programme exclusively of topics pertaining to obstetrics and gynecology,—but the surgical aspect of these branches should have such recognition as will draw to our meetings the general as well as the special surgeon.

While we would not expect ophthalmologists, and laryngologists to prepare papers on their special branches to be read before our society, yet they, and all other specialists should be encouraged to note carefully the relations of diseases, so that should their patients suffer from trouble entirely reflex, they may add their rich and varied experience, which would educate others who would not have such opportunities of observing the sympathetic relations of disease.

The general practitioner should be enticed to our meetings through the channel of the inseparable relations which must forever exist between them and the specialist.

If general practitioners could have the opportunity afforded the specialist in diagnosing obscure pathological conditions, their usefulness would be greatly increased and untold suffering avoided.

In conclusion I would urge the society to strive to secure the co-operation of prominent members of the profession who reside in the eastern and southern states, that we may have the benefit of their cultured experience and wise counsel.

On behalf of this society I extend to our friend, Dr. Joseph Price of Philadelphia, one of America's greatest obstetricians and gynecologists, who is present with us, the freedom of the floor, and cordially invite him to fill our granaries out of his rich and overflowing storehouse of knowledge.

We are to be congratulated that so distinguished a gentleman has honored us with his presence.

AFTERNOON SESSION.

THE VICE-PRESIDENT, Dr. Shreves, in the chair.

THE CHAIRMAN: According to resolution the first part of this afternoon is to be taken up in criticism upon the papers

read. The first then will be upon the paper of Dr. M. R. Mitchell, of Topeka, Kansas, "Asepsis in Obstetrics."

It was then moved and seconded that the gentlemen present, not members of the society, be given the privilege of the floor in discussion. Carried.

THE CHAIRMAN: Dr. L. A. Berger was appointed in case Dr. Woodson was not present, to open the discussion of this paper.

DR. BERGER: In view of the fact that our time will be somewhat limited I will not take up very much of it in discussing this question, but will make a somewhat short resume of the paper read by Dr. Mitchell. The society is to be congratulated that the subject of *Asepsis in Midwifery* has been selected as the first paper. Asepsis is the ground-work of all our work both in obstetrics and in gynecology. The most important truth that is impressed upon us by our experience with antiseptic measures in general and in surgical practice is this, that *cleanliness* is the foundation of all successful surgical and other work. A proposition has been made that every woman who has undergone accouchement is a wounded woman. I would add to that that every pregnant woman is an anæmic woman, and is entitled to the same care and the same attention that is given to any surgical or medical case. The great fault with us in our general work is that as physicians we do not instruct our patients of the necessity of asepsis—of absolute cleanliness. In this lies almost the greatest trouble in carrying out strict antiseptic and strict aseptic measures.

From statistics, not alone in this country but in the London General Hospital, we find that the mortality has been reduced; in the latter from 40 per cent. to 2.5 per cent., and in this country from 20 per cent. to 1.5 per cent. This should be and is evidence to us that asepsis is an absolute necessity. It seems strange that we have not made more progress than we have.

The question whether puerperal septicæmia is due to auto-infection or to hetero-infection is, as you are aware, a mooted one. But granting it is due to one or the other is no argument against asepsis. This infection we know of a surety may be carried by the physician himself. Why is it that to-day without any tremor, with-

out any trepidation, without any fear we go from a case of scarlet fever or diphtheria, or even from a case of puerperal septicaemia to an ordinary case of confinement? Simply because we have a safeguard in asepsis.

We are all agreed, I believe, that asepsis is simply a question of degree. It is simply a question of how one man may carry it out or how another may; but underlying it all is unquestionably cleanliness. The prophylactic measures that we may use I would illustrate by my own personal experience. The conclusions that we reach upon all these questions are based simply upon each and every man's individual experience. At the University Medical College for the past five years, in my obstetrical clinic, which began with some six patients, and in the past year provided for some eighty cases attended exclusively by medical students, we have not had one death. Our methods are based simply upon the same principle that Dr. Mitchell brings forward so plainly. We intend to render those who attend these cases positively aseptic. They may start immediately from the dissecting room to these cases. We provide them with all the means and measures for antiseptic dressings and attention. They are supplied with permanganate of potash, oxalic acid, carbolic acid and bichloride of mercury. Understand, gentlemen, that these cases are taken from every part of the city, including the north end near the river—from the slums if you please to call it so.

When the students arrive they first wash their hands and arms to the elbow in a bichloride solution, then in a saturated solution of permanganate of potash and finally in a solution of oxalic acid. The patient herself is provided, if possible, with fresh, clean underclothing. Very rarely is this the case when they arrive. The patient's limbs and abdomen are washed with the carbolic acid solution and the labia washed and dressed with a bichloride solution. An injection is made also. You understand, of course, that all this is done if there is sufficient time before labor takes place. The injection is of a bichloride solution of 1 to 3000. These directions are faithfully carried out. The gentlemen are not allowed to make any examinations with lard or vaseline or any preparation that the family

may have in the house, their hands are dipped in a bichloride or carbolic acid solution. I make no limitations as to the number of examinations. They can examine as often as they wish, but between and before each examination they are compelled to wash their hands either in the bichloride or the carbolic acid solution—preferably the bichloride solution. Furthermore, they are provided with a pad to catch all discharges, both before and after the confinement. After the confinement has taken place the patient is washed and cleansed thoroughly. No injection is made of any of the disinfectant preparations. Ordinarily we use the obstetric binder. The obstetric binder, I will state is simply a matter of convenience—a matter of preference—and we use it simply to meet a whim, as it were, of the women. The vagina is inspected to see if there are any lacerations. If so, and the laceration be superficial, the attendants are instructed to touch it with carbolic acid. If the perineum is torn or if there is any special laceration they send for me and I attend to that myself. After the patient, thoroughly cleansed, is placed in bed, we use a pad made of bichloride gauze and absorbent cotton. Sufficient gauze and cotton are left, with instructions to the patient to change it every six hours.

This in brief is the method we have been carrying out for the last six years. And personal experience, that which one meets with in daily life, is the best evidence of success.

DR. SHELDON: The only question I wish to discuss is whether the recommendation of the author as to the use of the douche after every labor, is altogether good. It seems to me, Mr. President, that it is not essential, nor proper, nor advantageous in every case to use a vaginal douche after delivery. If the necessary precautions as outlined by Dr. Mitchell, have been taken there is certainly no indication for the use of the douche. On the contrary, I can readily understand how the vaginal douche can, and often does, convey germs into the vagina and to the lacerated tissues wherever they may be, where they find a proper field in which to develop and grow.

Nature has well provided for cleansing the vaginal canal in the various steps of parturition. Almost continually for

some hours, or even days perhaps, before labor there has been a discharge which has constantly washed the vagina with an aseptic fluid. Then comes immediately or soon before the birth of the child, a flow of an aseptic fluid which further cleanses the canal. Following these, as if they were not enough, we have another process, and that is the passage of the head of the child through the canal, which certainly must further relieve it of infectious matter, if there be any. But that is not all. It seems as if Nature has provided a large cloth or mop, in the shape of the placenta which wipes it again and which with the flow must pretty thoroughly cleanse the canal. Now, as if that had not been enough, Nature provides another step, and that is the lochial discharge that continues for one, two, three or four weeks, as the case may be. It is hardly possible for any germs to enter the vaginal canal and lodge on those ruptured places in the mucous membrane, with all this antagonism to their entrance. We ought to remember, Mr. President, that as soon as the child is born and the placenta is delivered, the vaginal walls close down upon one another and there is no canal for the introduction of germs. It is closed; and this fact, in connection with the lochial discharge, which itself is an aseptic fluid, is eminently sufficient to prevent the introduction of any germs.

Just one more point. Suppose, as is usually the case, there has been more or less laceration of the mucous membrane in the vagina, or about the cervix, or slightly perhaps of the perineum. We do not say that it is extensively lacerated because that comes under another head. But suppose we have a ruptured mucous membrane in the passage. I would like some one to tell me what we are to accomplish by the vaginal douche after the labor. Isn't it a fact that if you use the vaginal douche with an antiseptic of greater or less strength, immediately or in a very few minutes thereafter, the whole surface is again flooded with a lochial discharge? Again, if you use antiseptics or germicides strong enough to destroy any germs that may exist in the vaginal canal, you will use antiseptics or germicides to injure the tissues more than do them good.

DR. TODD: Mr. President, I want to speak upon a particular point, inasmuch as it appears to me that the speakers as

well as the author, have omitted something very important. I wish to call your attention to the fact that, while asepsis or cleanliness is all that is claimed for it by the speakers, something more is needed. Asepsis excludes infection from the outside; but all infection is not hetero-infection. Now I wish to say that, during the labor or about the termination of the labor, besides resorting to these antiseptic measures we should see that the uterus is firmly contracted and that all coagula are thoroughly expelled. We should see that there is a firm contraction of the organ; for in that way these torn vessels are closed so that if a small coagulum remains there will not be decomposition, and the danger of absorption is at a minimum. The idea is to so close these bleeding vessels by contraction that there be no more bleeding, and that even the smallest coagulum shall be expelled. Thus there will be nothing to undergo decomposition and be absorbed by the lymphatics and veins, and asepsis will be preserved. Understand, I do not undervalue the importance of asepsis, but that is not all; and, speaking from an experience covering thirty-five or forty years and extending back to a period long before asepsis was known, I could give a record that would astonish you. Cleanliness was the means by which infection was prevented and the recovery of the patient assured. It would astonish you to know how much could be done without any knowledge of asepsis. But I do not depreciate the value of asepsis at all, for now-a-days, with the aid of all these aseptic precautions, very few patients need die in a puerperal condition.

DR. DEWEES: I wish to endorse in a measure what has been said by the speakers thus far. One point I wish to insist upon and to place myself on record, is that our office as obstetricians, is simply as overseers and helpers. First, as overseers we are simply to watch and see that Nature is doing all that need be done. So long as Nature fulfills her part, so long are we, above all things, not to become meddlesome. As helpers, we are simply to act when we find that Nature is obstructed in one way or another. These offices are fulfilled, as Dr. Mitchell suggested, as to the external part of the woman; but as to the internal douching, I wish most strenuously to disapprove of the procedure un-

less there is a septic condition calling for its use. Once the woman is clean and the physicians' hands are clean, there is no more harm in introducing a hand or finger into the vagina or womb than there is in introducing it into the mouth. As for cleanliness of the hands of the obstetricians, I know of nothing better than the use of cyanide of potassium, the most powerful microbicide that we know. True, it may be dangerous if one has excoriations on the hand, but otherwise it is not dangerous and is an absolute cleanser. Subsequent to that, I use nothing but salt and water. I invariably have a pitcher of hot water brought into the room by the nurse, and into it I put enough salt regardless of quantity, to make a good strong salt brine. I have that covered, and pour a little into a basin as I need it. At the beginning of each examination I dip my hands into it and make my examinations, after which I use clean water and soap.

DR. TODD: I wish to supplement my remarks by saying how the uterus should be compelled to contract and to expel anything that should come away or that might by remaining decompose and be absorbed. Just at the close of labor I resort, as I presume most physicians do, to the Credé method. But I want to call particular attention to the value of it to compel contraction. I don't leave off compression until the uterus is firmly contracted to a hard ball beneath the hand; and when that is done, I know that there is no coagula lodged in its cavity and no coagula lodged in the vagina. To make sure of this, I am in the habit of allowing my patients to get out of bed to defecate or to pass urine, no matter if it is only an hour after delivery. I allow them to get out of bed or walk across the room; I mean I don't restrict my patient to the bed. Those who do will find trouble from coagula remaining in the vagina. Besides, if put upon the feet the motion will assist the uterus to contract and expel the coagula. By a kneading with the hands and the motion of the patient you can compel the uterus to completely evacuate its contents.

DR. DANNAKER: Speaking of asepsis in obstetrical practice brings to mind a case of long-delayed delivery, where the amniotic fluid came away at four o'clock in the afternoon. I was called near six o'clock the following morning, and on

examination, after going through all the preliminaries, cleansing my hands and the parts—I always carry a fountain syringe with me for the purpose of cleansing the vagina—at first on making an examination I could not make out the os, but by putting my finger back I came into contact with the sacrum. Then putting my finger in the os and bringing it forward I could make out the position of the fetus. I applied the forceps, but during all this time I kept the parts thoroughly doused with hot water—no antiseptic whatever,—and brought the child into the world by this process. By this application of hot water to the vagina I had no trouble in the after-recovery of the patient. That is one particular point I want to make when you have those long-delayed deliveries where the amniotic fluid has come away, it is necessary to keep the parts softened, and the only way to do it is by this hot water application.

I wouldn't feel safe in using a carbolyzed solution any length of time, or a bichloride solution; but by the use of hot water you have all the effect necessary and in addition, you cleanse out the vagina, bring on the contractions and help the woman towards recovery. In regard to vaginal douches after the child has been delivered, and the after-birth discharged, I not only use my finger on the pulse, but use my nose. Every time I come, I lift the bedclothes and use my nose, and if there is the slightest odor I do not hesitate to order the douche, and I administer that douche myself for the purpose of cleaning out the parts. I think it is absolutely essential in all cases where there is the slightest odor. It behooves a medical man to use his nose just as much as a thermometer in those cases.

DR. SHREVES: There is one point I had hoped some member would notice, and that is the use of the vaginal douche prior to the birth of the child. If we take this as good practice, we must acknowledge that Nature made a sad mistake from the beginning. From twenty-four to forty-eight hours prior to the delivery, we find the vaginal tract thoroughly lubricated with a tenacious mucous secreted by the mucous follicles surrounding the tube, evidently the original design of Nature. Now if you use the vaginal wash prior to delivery of the child, you

wash away this lubricating fluid and leave this membrane denuded of that material placed there for its protection. With regard to the after-washings I would take the view of the other gentlemen, and say that it is only necessary when there are indications of septic influence. Especially is this the case where you haven't an experienced nurse. If you have an inexperienced nurse the probabilities are that she is a little bit timid and the water may not be quite warm enough and she may do harm; while if you have an experienced nurse, no harm will come from washing the vagina every day. But unless there are indications of septic influence, and unless there should be a foul odor present, I wouldn't direct my nurse to use the douche every day. But in case there was an odor, whether the nurse is experienced or inexperienced, I would direct the use of the douche if it was not possible to administer it myself.

DR. MITCHELL: I thank the gentlemen for the discussion of the two or three points to which attention has been called, and to which issue has been taken. The first one is in regard to the use of the vaginal douche, either previous to labor or subsequent to labor. It has been objected to because it is not necessary; because it removes an essential fluid used for lubricating the parts, and because it is risky or dangerous. It has been argued that it is not to be used unless it is needed, and that is when you have a septic condition. A septic condition, of course, would necessitate or make proper its use. Now, as I tried to make it appear in the paper, aseptic maneuvers are largely for prevention. If we are liable to have a septic condition, which all the gentlemen have virtually acknowledged, I think that liability is sufficient evidence to prove that precautionary measures should be used.

I cannot see why the douche is, or can be, injurious in any way, especially by removing or washing away the secretions that serve the purpose of lubrication. We know that those glands secrete freely and continue to secrete, and the supply is not wanting when the passage of the child comes. Even if you do use the douche previous to labor, the reproduction of this secretion is not affected and lubrication is plentifully supplied.

As regards the danger of introducing septic matter by use of the douche, if you

conduct your procedure with strict care in every particular there is no necessity for introducing any septic material whatever.

I admit that the vaginal discharges are usually aseptic, but very frequently they are not. Why is it that we so frequently have end metritis? It is on account of secretions in the vagina, and I think the majority of women previous to labor have more or less leucorrhoeal discharge which is not aseptic and which is liable to become septic on a lacerated surface. I referred to the method of contracting the womb in my paper, but perhaps I did not put enough stress upon that point and I am glad the doctor has presented it. It is certainly one of the necessary and, indeed, the most important of procedures to obtain and preserve aseptic conditions; that is, shutting the doors and preventing the entrance of septic material. Thorough contraction of the womb, and seeing to it that it continues contracting, is a very essential part in connection with aseptic treatment.

I think the use of hot water very good. Hot water is a very good material to use in promoting or in preserving an aseptic condition. In fact, I very frequently use it as a vaginal douche—simply boiled water as hot as the comfort of the patient will admit of.

THE CHAIRMAN: As Dr. Price has just arrived I will say for his benefit that there has been quite a little discussion upon this paper, and that the privilege of discussion is extended to all present and is unlimited as to time. We shall be very glad to hear from you.

DR. JOSEPH PRICE: I value the discussion of papers sometimes very much more than the papers themselves, and I am very glad to hear the Chairman say that there is no time-limit to the discussions. Unfortunately in our society meetings in the East we have limited the time to three or five minutes. We have been governed very much by the Marquis of Queensbury rules—three minutes to a round. That men of average experience, who have traveled a thousand miles with the best they have and the best they know, should be rapped down in three minutes is a mistake. But it is so in all our national organizations and in our state societies, and there should really be some stop put to it. It keeps a number of good men away from county,

tate and national organizations who have something to say that is valuable and which should be placed on record.

Dr. Mitchell very kindly referred to the Preston Retreat in Philadelphia. It is an institution more than fifty years old. It hasn't that polish and shine about it that the Sloan Maternity of New York, or the Hopkins of Baltimore, have, but the construction and arrangement of the institution is about perfect. In short I feel that most new institutions would do well by patterning after this old one.

It is of very peculiar construction; a large square building with a veranda surrounding at least two-thirds of it. The wards are entered from this veranda; the wards touch the house on one side only and are isolated. It is peculiar in its cruciform shape, favoring ventilation. The plumbing is all outside of the building not inside; at least, it has been so since I have had charge. There is not a pipe in the building. You can all very well remember that the privy was back of the garden when you were boys. Later, it was moved up to the house side of the garden; still later into the back yard; the next move was up *against* the rear of the house, and the next move in the rear of the house just *inside*, and now our houses are simply hoppers to a sewer with the plumbing all amidship. What we call modern sanitary plumbing is tapping the sewer at the first, second and third floors in our homes and residences. There is no reason why all plumbing should not be outside the house by three or four feet, with a circulating atmosphere between the house and the pipes. This should be so in all houses and hospitals. No hospital should have plumbing in it of any character whatsoever. *Always* there should be a *circulating atmosphere between the plumbing and the house or hospital*.

Now as to the isolate work of the Retreat. The wards are large, well lighted and well ventilated. In the paper referred to, all of this was dwelt upon at some length. The ceilings are high; the wards are wide, the windows are large and there is an open fire as well as modern methods of heating. The plumbing is distanced. There is a circulating atmosphere at two points between the wards and plumbing proper in the brick piers at the corner of the house continuing from it.

The toilet of the patient is just about

that given in the paper. The patients are admitted theoretically two weeks before delivery—a wise provision for a woman approaching the perils of childbirth. This unfortunately has not been so in the maternities all over the world. I think it is simply cruel to admit a woman in labor, and to discharge her on the tenth day—simply cruel. It isn't right, and should be stopped. At the Retreat they are admitted two weeks before, and they may remain four weeks after. You see the period is much longer than in any other maternity. When admitted to the house the patient has a bath—a thorough bath; her soiled clothes leave the building and go to a laundry some distance from the hospital. While awaiting delivery she takes two soap baths a week; the bowels are kept soluble, and if there is a suspicion of any renal trouble, the urine is examined. When she complains of labor pains she is given a soap bath, a vaginal douche of 1 to 2,000 bi-chloride of mercury and an enema, and she enters the delivery room in clean clothing.

The delivery room is cared for by a clean nurse who has nothing whatever to do with the puerperal patients while caring for the delivery room. The nurse and doctor both scrub thoroughly before entering the delivery room. I allow but few examinations and but little meddlesome midwifery. I examine the patient only once and go off and read, or lie down until the head is about ready to clear the perineum. The forceps are very rarely used. The woman and nature still know how to do their own work. The women are permitted to have their own children and I find it a wise if old fashioned practice.

At the present time there is unquestionably, in private and in public, a tendency to make too many artificial deliveries. And just here, had I the time to demonstrate the mischief and evils of the premature application of the forceps or of hasty delivery, I think I could add something at least, to the list of vicious sequelæ of child-bed that we are so often called upon at present to repair. In short I am satisfied that foolish obstetrics is responsible for so many private sanitariums, and for so many gynecologists established over the land. Lacerations are bound to occur. No doubt there were lacerations in Eve's cervix, and may be in her peri-

neum; and in a great many women there have been a great many since, and will continue to be. After delivery of the child, there is delivery of the placenta by the expression method; and then a vaginal douche. This post-partum douche ends all. The ante-partum and post-partum douches are the only douches given.

Now I know very well that some of you practicing in healthy country districts are a little surprised that these douches should be used. The ante-partum douche I value more for saving the eyes of the babies, than I do for saving mothers. I am satisfied that in my own state of Pennsylvania, if every woman delivered in the next ten years should have an ante-partum douche of a one to two thousand mercury solution, it would reduce our blind asylums from ten to one; that ophthalmias would scarcely be heard of. My nurses at the Retreat are just as ignorant of ophthalmia as I am of leprosy. If you should visit that institution and ask an intelligent, painstaking, clean nurse, "Have you any ophthalmia?" she would smile and say no; she could not answer your question, or if so she would answer it simply from her knowledge of what she had read. To demonstrate just what the ante-partum douche will do in saving eyes, I will call your attention to three cases—one delivered in the gutter before the house as she stepped from the carriage; another in the hallway on the way to the delivery room and the other while in the bath. There was no ante-partum douche in either of those cases and the three babies had ophthalmia. I know perfectly well while discussing this question, that many of you wonder at the occurrence of ophthalmia and post-partum troubles in a great city, when they never occur in your healthy agricultural districts; but let me say that they do occur in the healthy agricultural districts and in small towns. For instance, the wife of one of my acquaintances in Johnstown was recently delivered, and the child was blind in three days. Now had this woman received a careful ante-partum douche and a careful toilet, this would not have been so. The man, the husband, had been unquestionably a victim of gonorrhœa and his wife was contaminated.

In dispensary work—in the alleys and courts of large cities—in railroad towns, the population is largely the victim of

specific vices. In healthy rural districts it is not so. You can, as a rule put your finger on the contaminated woman or man in the agricultural districts. It is usually a young medical student, a drover or a drummer; but not among the clean, religious, spotless class of people. I know perfectly well, just as well as you do, from my intercourse with men of large experience and rare good judgment in the rural districts, that all this toilet is not necessary. For instance, I have friends in the valley of Virginia beginning at Winchester and running clear through to Staunton. A cousin of mine tells me that he has delivered fourteen hundred women and never had an ophthalmia, and yet he never gave the vaginal douche. There is Martinsburg, Winchester, Woodstock and other places where I have talked to the doctors in regard to such troubles, and they give me precise knowledge of their own work.

In dispensary work without douches, we have had a large number of ophthalmias. I know early in my own experience in dispensary work, I attended between 150 and 200 women every six months, and had great numbers of ophthalmia cases. Some of them lost their sight notwithstanding I used full strength solution of silver and other things. Taking the baby's head between my knees and going into the conjunctival sac and using a strong solution, I didn't succeed in saving all eyes. At present with seven or eight hundred cases to distribute among undergraduates, the instructions given to students are about as follows: The patient is advised when she applies for some one to take care of her in her confinement, to have her bedroom house-cleaned a few days before she expects to be sick; she is advised to take baths and to keep her bowels soluble. She is told she will be safer if she will have her bedroom house-cleaned a few days before she expects to be sick. We have a nurse that makes a visit to these persons, makes the toilet of the mother and child and goes on to the next patient. The student is told to take a syringe and some tablets or whatever he may be taught. The Jefferson student and the University student are taught very different stuff. He is told to practice what he is taught; to give the ante-partum douche and post-partum douche, and to give it himself; it will be

practice for him and do him good. He commonly gives the douche. He is told to use soap and brush thoroughly before and after each examination that he may make; that he may have the privilege of making examinations, auscultation and palpation and practice touch providing he uses the soap and brush freely; that the patient does not object to it and that she thinks he is painstaking and careful if he does examine frequently; and I make no objection *providing* he uses *soap* and *brush* *freely*. I find no mischief comes of it. This practical work is of great value to him; the care over five or six cases in the alleys and courts of a large city before he returns to a small town in Texas, Kansas or Tennessee, puts him at ease at his work when he gets home. And out of some 790 cases last year, in 780 there was not a single death from any form of post-*puerperal* or inflammatory mischief, no fevers, no chills or anything of that sort.

There is a great deal said in Germany about students examining. Some of the maternities take very high ground of recent years in regard to undergraduate work. The position is untenable. The rich have to take care of the poor. You will go into your own pocket books and into your own homes, towns and districts for that purpose; you must have something for it, and no harm can come from good honest work. The general mortality in *puerperal* fever is large throughout the country—no question about it. It remains large. In some small cities and towns where I have made careful inquiry, I discovered sometimes the mortality was very high. For instance the last eighteen or twenty months some seventy women have been reported in Scranton, Pa.—seventy deaths due to post-*puerperal* trouble; and in Paterson, N. J., in the last twenty months, some twenty women have died of *puerperal* fever; and within the last year in Philadelphia, in private work we have had a large number of *puerperal* fevers; for instance, one dying or dead within a square of my house—dying of *puerperal* fever. I saw her before leaving home.

Now in regard to irrigation and the use of the curette in post-*puerperal* troubles. In my own practice I have never had occasion to use either, either in Dispensary or Retreat or in private work. I have never used it except once or twice in in-

tra-uterine irrigation; and I do believe that more mischief than good comes from intra-uterine tinkering. For instance a physician did a very thorough curetting and washed out the uterus, and the next day the patient had a chill and the temperature went to 105°. Now it is very curious that in many of these post-*puerperal* cases, the temperature goes very high after using the curette and intra-uterine douche. One case that I am referring to, the wife of a physician in our city, was confined during that excessive heated term, and on the third day had a high temperature and I am under the impression it was thermic fever; at the Retreat I had several cases of heat exhaustion. I hadn't a suspicion of post-*puerperal* trouble; I thought it was excessive heat; I thought they were all thermic fevers and I treated my cases as such and got good results. But on the fourth day they used a curette on this lady I refer to, and the following day she had a chill and her temperature went up to 105°. An additional consultant was called in, and he argued that probably the curetting was not sufficiently thorough and wanted to repeat it; and the use of the curette was repeated with a douche, and still her temperature remained high. Then they agreed to remove the uterus. After removing the uterus, they found a little puddle of muddy fluid in one of the sinuses. I naturally ask you did this little puddle of fluid follow the use of the curette, or did it antedate it? Did it follow the displacing of this clot or sealing this sinus, or did it antedate it? It is my impression that this puddle of muddy fluid, or pus fluid, followed the use of the curette and did not antedate it. Take the cases that you have now in bed—post-*puerperal* cases—and curette them all, and you will scrape away a lot of decidua vera that you may be pleased to call *debris*, and think that it ought not to be there. Not so; it ought to be there; it is so in every woman; it is a healthy dressing for the *puerperal* cavity. It should not be a *suspicion* or *guess* that there are some lurking or remaining membranes or placenta that induces you to curette her or douche her. It must be something more than that that makes you use the curette. It must be something *positive* and *definite* that warrants a procedure of that character, and I hold that simply a suspicion or a guess does not war-

rant it. I will say that my practice is not that of curetting or washing the cavity of the uterus where I am unable to put my fingers on something else.

DIRTY MIDWIFERY.

We all very well know that midwifery has never received that attention in private or public that it should receive. Many years ago, you probably remember, a lengthy discussion took place in Dublin, lasting some nine days, where they discussed pointedly the abolishing of the maternities. These were animated discussions indeed. And they did close the maternities all over the country, and from time to time continued to close them. The Queen Charlotte, of London, was closed a number of times on account of puerperal fever, for patients died in large numbers. The New York hospital maternities were closed and scrubbed out, and they tried it again. The Lying-in-Charity, of Philadelphia, and the old Lying-in-Charity of Pennsylvania hospital, were all closed for a time. The mortality ranged from five to some forty per cent. in the maternities. Now, we very well know that the very best work that is done on the face of the earth is done in maternities. When I took charge of the Preston Retreat—not that I wish to pat myself on the back, but I took charge of it to win—I saw no reason why a maternity should not be managed with a nil mortality, and I bent my efforts to that end. I have now delivered over twelve hundred women without a death from any cause, with that prolonged period of confinement of two weeks before and four weeks after, giving me of course a longer period for patients to die than that of any other maternity on the face of the earth, and I have not had a death of any patient either from eclampsia or any other cause. There has not been a death within the walls.

I have alluded to errors in plumbing. Just here I might refer to what takes place in tenement houses. I remember very well some years ago we had a number of tenement houses in the city—one on Front Street that we called the forty family house. The students used to come to me and say,—“Doctor, I have a patient who has had a chill to-day; I wish you would see her with me.” I could name four or five houses in which this took place. With the patients who lived in

alleys and courts with a cesspool in the rear of the court,—even in small houses, three rooms one above the other, three families in these three rooms—three families in a house—we rarely ever had trouble. Notwithstanding they did a general housekeeping in these three rooms, children sleeping on the floor and man wife in a small bed, it was exceptional to have any post-*puerperal* trouble in this illy-ventilated, dirty little room. But in the old tenement houses with the plumbing amiships, between the first, second, third and fourth floors, *puerperal* troubles always occurred. I made this statement five or six years ago in Newport, and it brought the distinguished obstetrician Lusk to his feet who said Dr. Price's statement corresponded precisely with his own observation; that he had made that observation frequently, and maintained that the plumbing frequently had much to do with post-*puerperal* mischief.

Night before last, when I left Philadelphia, I noticed behind me on the cars, three crying children. It troubled me. There was a distressed-looking man wrestling with these three children. The porter came by and I said—“Porter, is that man's wife dead?” He said—“I don't know, I'll find out.” The porter got a glass of milk for the children, and made every effort to quiet them, and then asked the man if his wife was dead. He said—“Yes, she died three days after child-birth.” That had as much to do with me taking part in the discussion as anything else; because I have discussed it so often that I sometimes think that I tire you, and some other subject would be much more welcomed; but I knew too well how exceedingly distressing this subject has become. I insist that hereafter the whole profession pay more practical and theoretical attention to this subject of paramount importance. We are all fathers and we should think more of the perils of child-birth and the care of tender mothers.

DR. DANNAKER: I would like to ask Dr. Price what covering the walls have in the Preston Retreat?

DR. PRICE: Paint only.

DR. DANNAKER: Not calcimine or whitewash?

DR. PRICE: No, sir; paint only. Just painted and washed.

DR. DANNAKER: Do you give the vaginal douche while she is taking the last bath?

DR. PRICE: There is no douche until she commences labor.

DR. DANNAKER: Do you have an inflow pipe in the room?

DR. PRICE: No, sir; tea-kettle in the delivery room; never leaves it. The delivery room is large and wide. On the bed there is just a clean hair mattress with a macintosh to cover it, and two clean blankets. She has her bath and her vaginal douche—glass douche-pan. This bath is outside of the delivery room. Before taking the bath an enema is given, and she evacuates the bowel before she enters the delivery room. The nurse makes her toilet—puts on a clean apron—makes her toilet entirely. She is not even allowed to keep her tooth-brush in the same mug with her hand-brush. I only allude to this to show you how far military discipline goes. It should exist in every hospital. If you can't have military discipline you don't have any discipline. I believe every doctor and surgeon should be a West Pointer for a while. It would do him good, particularly the surgeon and his assistant. I allow but few examinations; no washrags and no sponges; there is not a sponge or washrag to be found in the house, but we use corrosive jute—marine jute prepared chemically. You perhaps think I am *ultra* in my cleanliness or in recommending such a toilet, knowing, as some of you do, that I condemn all chemical solutions in surgery except for the purpose of obtaining cleanliness. Surgical cleanliness, if you can obtain it at any cost and by any means do so—chemically or by soap and water; but keep away from all surgery all irritating chemical solutions. For instance carbolic acid gives a variety of troubles. Mercury does pretty nearly the same thing. Carbolic acid gives you that numbness and tingling that is noticeable in sclerosis of the cord, and gives you a non-surgical hand as well. A mercury hand or carbolic hand is not safe from two points of view; being an irritating hand, and not being a perfect tactile hand. Chemical cleanliness in surgery or midwifery is the purest sort of cleanliness; hence I use corrosive jute. The sponge is exceedingly difficult to clean; it takes days or weeks to clean it properly. The surgeon only should

clean his sponges, and nobody else. Corrosive jute is the cleanest material you can use.

DR. TODD: Prepared by whom?

DR. PRICE: Prepared by Johnson and Johnson. It is nice and as soft as silk. You can make it into little washrags, and while the patient is in labor, a little washing about the vulva and about the bowel is all that is necessary. Now the delivery room contains two basins, two pitchers, scrubbing brush, tea-kettle and a gas stove. That is all. Those pitchers only leave the room to be filled with water, that is all. Those pitchers, tea-kettle and basins are used for no other purpose. Sometimes in private I feel at a loss for the simplicity of the delivery room; but you can have in private, just the same simplicity at little or no expense. For instance, the patients at the Retreat will change beds thrice. When admitted, a single hair mattress; when delivered, single straw mattress; when convalescent a wide hair mattress. Now you say you can't go to that trouble or expense in a small city. I think that is a mistake. A woman comes to you and asks you to take care of her during confinement, and probably she has a bed fifteen years old in her room. It will be a very simple matter to have three bundles of clean rye straw with a blanket folded over it, and a draw-sheet over that; that makes a good clean bed. Surely better than a bed saturated with urine. Perhaps one on which two children have died from scarlet fever or diphtheria. It is unsafe; it is contaminated and should not be used for childbirth. I know that some teachers condemn the straw bed. Parvin objects to it in a maternity. But you can buy one, or two, or three tons of clean rye straw, store it in a dry place and the beds can be made up and placed in a dry room, as dry and sweet as can be and will never become contaminated. We use as a cover simply a clean mackintosh with four thicknesses of blanket over it. I never allow anything to have a spot on it. The nurses are instructed to make their toilet before touching the patient, and to repeat that toilet before touching patient No. 2, and to repeat it again before touching patient No. 3. They are instructed to remove the draw-sheet and bed gown whenever it has a spot on it. Don't spare the laundry. There has always been a peculiar state of

affairs in maternities and hospitals that I can never understand, namely of sparing the laundry and laundry women and soap and water by changing sheets once or twice a week. Why, if forty times a day there is a spot on draw-sheet or bed gown, it

must come off. And that holds precisely the same in the maternity as it does in my private hospital where I have to pay for it myself. And I think that we will all come to it after while, that we will have a Sunday morning laundry.

CORRESPONDENCE.

"INNOCENTS ABROAD."

EDITOR MEDICAL AND SURGICAL REPORTER:—I have been a subscriber of your journal for some years, during which time I have found few articles to criticise, but "Innocents Abroad" in the number of February 11th, I think is calculated to do a great deal of harm, inasmuch as it tries to make it appear ridiculous for a physician to visit Europe for post graduate work.

Now as I have had the pleasure of such instruction I cannot think it but producing a false impression that any such course in a European University is time wasted or that the American physician goes to Europe "to sit at the feet of some stupid privat-docent."

The great mistake is in any person going to a foreign university when he is not acquainted with the language spoken, and where his time could be better spent in New York, Chicago or Philadelphia.

Puffing at a meerschauum "unter den Linden" is not studying medicine.

During my stay in Prague in the Lying-in-Hospital, where in the two departments they have from forty to fifty births daily, I had advantages which are not to be had for money here, and the amount of fees paid in did not exceed twenty-five dollars.

The Rotunda in Dublin does not offer such obstetric advantages.

It seems to me that before any medical journal should pooch-pooch European Post Graduate courses, that they should furnish like advantages here.

The American people know a thing when they see it, and if the advantages there were not superior to our own they would not go that distance to procure them.

The writer of "Innocents Abroad" must know that neither the University of Pennsylvania, Jefferson, or Harvard, can

furnish any such obstetric advantages as before described, and those given are monopolized and overrun.

A physician going to Europe if he knows where to apply, can get advantages not dreamed of in America.

Where in America can we find such a clinic for venereal and skin diseases as are furnished by Profs. Neumann and Kaposi, of Vienna?

The immense material for skin diseases, nose and throat, and surgery in Prague are not used by the foreigner, not on account of the names of Prof. Pick and Gussenhauer being unknown, but because so few know of the immense advantages offered in that city.

My advice to any German-American physician is first to practice a few years after graduating and then take post graduate work either in Prague, Vienna or Berlin, according to the advantages wanted.

If such a physician goes and uses his time properly, it will take a great many such articles as "Innocents Abroad" to make him believe that he has wasted his time, or that the same advantages could have been procured here.

O. C. STRICKLER, M. D.
New Ulm, Minn.

"Madam," said the doctor in answer to the earnest inquiry of his patient, "you are suffering from a complication of disorders, the exact nature of which can only be ascertained at the post-mortem."

"That is a very fine dog you have, Johnny."

"Yes, but he is consumptive."

"Consumptive! Why do you say that?"

"He's Spitz blood, you know."—*Ex.*

NEW YORK LETTER.*

At a recent meeting of the New York County Medical Society Dr. T. A. Emmet read a paper on "The Means of Success in Gynecological Plastic Surgery." He mentioned in the beginning, that while the fad for abdominal surgery had materialized a large number of expert laparotomists in this country, the skill requisite for plastic work had been almost lost. There is both lack of dexterity in operating and incorrect ideas of what is to be accomplished, hence many dismal failures result. In his paper he claimed that but one plastic operation should be undertaken at one sitting, and that many failures were due to the fact that two or three operations were performed at the same time. When only a single operation is done there is a much better chance of obtaining union by primary intention. He said the cause of the troublesome symptoms in laceration of the floor of the pelvis is a lack of support to the blood-vessels. Several years ago Dr. Emmet devised both the butterfly and the trefoil operations and he claimed that these, with the recent modifications he has added to them, will repair the damage; but that the dash-board-like obstruction put up at the vaginal outlet by some operators has not been successful. While he has always been able to repair any injury to the female genital tract, produced by usual causes, he has had much trouble in repairing those injuries left by poor surgery.

Dr. Emmet says that he owes his success in operations about the female genitals to the use of the silver-wire suture, which is not only a suture but a splint; nothing but silver wire should be used in plastic work about the vagina.

In the discussion that followed Professor Munde classified the essentials of success in plastic surgery about the female genital organs under the following heads: (1) Proper selection of cases. (2) Proper selection of time for operation. (3) Proper preparation of the parts. (4) Perfect asepsis including strict cleanliness, but avoidance of very strong germicides. (5) Rest, yet early, movement of the bowels. Dr. Munde disagreed with Dr. Emmet in the necessary use of the silver-wire suture.

He has employed with success, silk in the anterior vaginal wall and silk-worm gut in the perineum. He also said that more than one operation could be done at a time, and that he has often saved women much time, pain and expense by performing several operations at one sitting.

At a recent meeting at the Academy of Medicine, of the Section on Obstetrics, Dr. J. Harvie Dew read a paper describing his method of resuscitating still-born children. The method is original with Dr. Dew and because of its simplicity has taken precedence of the harsher and more dangerous methods of Schultze and of Schroeder. Dr. Dew has employed the following method since 1871. He grasps the newly born babe with the left hand, the neck resting between the thumb and fore-finger, with the head falling far over backward, thus elevating and holding open the epiglottis by means of stretching the larynx and the trachea. The upper portion of the child's back rests in the palm of the hand; the other three fingers rest in the left axilla, raising the shoulder upward and outward. He grasps the right knee between the thumb and forefinger of the right hand, the left knee between the fore and middle finger of the same hand; thus the back of the thighs rest on the palm of the hand.

With the infant in this position the pelvis and lower extremities are depressed, and with the left hand the upper portion of the spine is greatly forced backward. This process draws down the diaphragm, thus enlarging the thoracic cavity and produces inspiration. Expiration is brought about by reversing these movements. The left hand carries the shoulder and chest forward and the right hand raises the pelvis and strongly presses the thighs against the abdomen. Thus the thoracic and abdominal viscera are forcibly crowded together, and a perfect expiration is executed. This process is repeated until the child breathes.

Although the process is powerful it can be produced without injury to the delicate tissues or viscera of the child.

The author of the paper said that many years of experience in the obstetrical field had proved to him that his method was

*Special Correspondent to MEDICAL AND SURGICAL REPORTER.

the most efficient and uncomplicated one of working artificial respiration. It is not tiresome to the operator, and can be kept up with the child immersed to the neck in water.

In the discussion which followed, Dr. G. T. Harrison said that he could truthfully vouch for the efficiency of Dr. Dew's method; that the process fulfilled the three indications in asphyxia of the child; it freed the air passages of mucous and whatever the child had inhaled in the way of foreign bodies; it carried air to and from the lungs, and it stimulated the movements of the heart. He said that the Schultze method was dangerous, particularly in the hands of a beginner or an awkward physician, as fractures, dislocations, and injuries to the thoracic and abdominal viscera often resulted from the violent handling of the child which the method necessitated.

Dr. Grandin said that he considered Dr. Dew's plan of very great value, and that he spoke from experience, having tested it in a large number of cases.

Professor Lusk stated that it was an excellent method and because of its simplicity and good results should be extensively practiced. He said that shortly after the child was born the use of a catheter to inflate the lungs was a good procedure.

The Hygienic Institute of the University of Berlin has published the following conclusions, after repeated experiments made with relation to the spread of the cholera germ through cigars and tobacco.

The comma bacilli of cholera Asiatica die through drying up on dried tobacco leaves even quicker than through drying up on glass, and in this condition they die in an hour on an average. On moist tobacco leaves the comma bacilli do not increase, and are killed after a short time. The comma bacilli were not proved to exist in the examples of cigars manufactured in Hamburg during the prevalence of the epidemic. Through the fermenting and drying processes which cigars must undergo before they are ready for shipment, the cholera bacilli are killed after a short time, even when packed by way of experiment in the linen bands about the cigars. Tobacco smoke checks the development of cholera bacilli and is quickly fatal to them.—*Phar. Era.*

Cunelhysterectomy—A New Operation for Flexions of the Uterus.*

Thiriar reports a case of a cure of ante-flexed uterus by operation under the above name. Having borrowed the idea from the operation of Osteotomie for genu-valgum. After opening the abdomen he draws up the uterus, then resects an elliptical portion, 2 cm. in width, which extends down through the muscular structure of the uterus to, but not into, the mucous membrane. This section is removed at the point of flexion. The uterine wound is sewed with catgut and the abdomen closed. An iodoform tampon is placed into the vagina, presumably, to hold the uterus in position, until the cure is established. Thiriar has reported his case as having remained cured for two months after which he lost sight of her. [This certainly seems to us a heroic measure for the relief of an ante-flexed displaced uterus. It would be interesting to know the future history of such a patient including a possible pregnancy.—Ed.]—*Annal. de gynécol.*, 1892. Oct. p. 26.

A Costa Rican Costume.

The doctor, the author, the farmer and I were talking of travel in far foreign lands, the most entrancing topic of conversation on earth, and the doctor told this story:—

In the Spanish American countries, it is customary for servants and young people to go about in the hot weather almost naked, though they usually wear hats on account of the glaring sun.

One day a Costa Rica grocer sent his boy to deliver some goods purchased by a family newly arrived from more inclement latitudes. The boy was wearing a sore toe and a brunette smile. When he returned he brought the grocer a note, vigorously objecting to his attire or lack of it.

"Caramba!" said the grocer sternly. "You young villain, don't you ever go to that house again without putting on your hat!"—*Ex.*

Patient—"Doctor, let me know the worst."

Doctor—(absent minded)—"Your bill will be two hundred dollars."

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SATURDAY, MARCH 11TH, 1893.

EDITORIAL.

THE REDUCTIO AD ABSURDUM.

DEPARTMENT OF PUBLIC CHARITIES.
PHILADELPHIA, March 2, 1893.

To the Board of Management of the State Hospital for Insane for the Southeastern District of Pennsylvania:

Gentlemen:—At a meeting of the Board of Public Charities of the Commonwealth of Pennsylvania, held yesterday in Harrisburgh, the following preamble and resolutions were unanimously adopted:

WHEREAS, This Board at its meeting in December last considered a report presented to it by the Chairman of the Committee on Lunacy, and authorized its transmittal to the Board of Management of the State Hospital for Insane for the Southeastern District of Pennsylvania, and

WHEREAS, It is evident that that portion of the report setting forth that the management of said hospital were permitting surgical operations of an experimental nature to be made upon their patients is incorrect, and based upon erroneous information, and

WHEREAS, No surgical operations of such character have either been performed or proposed at this Institution, therefore be it

Resolved, That the Board hereby with-

draws said report transmitted as aforesaid, and further

Resolved, That, as the said report was made public without its sanction, this Board waives any objections to the management of the Norristown Hospital making public these resolutions in any manner they may deem proper.

Yours very respectfully,
CADWALADER BIDDLE,
General Agent and Secretary.

These resolutions which are in answer to a communication from the Board of Trustees of the State Hospital for the Insane, at Norristown (given in full in the last issue of *THE REPORTER*), command respect and admiration.

Perhaps it is not infrequent for such a body as the State Board of Charities to find out that they have made an error, but it certainly is rare for such a body of men, after being misled by their own agents, to frankly acknowledge their mistake, and so speedily to rectify it.

The State Board of Charities deserves the fullest commendation for this last action. Their communication is a digni-

fied acknowledgment of an error committed, an honest expression of regret, and a prompt rescinding of an injudicious action. It is more. It is an indignant repudiation of the men who misled them, and the methods by which they were deceived.

It can readily be understood how the Board were led into this action by their Committee on Lunacy, when it is remembered that the Board is compelled to rely largely upon its professional members for opinions on technical questions. This fixes the responsibility upon the Committee on Lunacy. Fortunately for some members of the Committee on Lunacy the responsibility can be narrowed down still further. Three of the five members of the Committee supported the passage of the above resolutions; the other two—the professional experts—were too busy to attend the last meeting of the Board, after finding that body not disposed to “quietly drop the matter.” This fixes the responsibility upon the professional experts.

A typical *reductio ad absurdum*.

The serious side of the question being thus disposed of, leaves only the amusing for contemplation, and as it would be unfortunate for the cause of Professional Philanthropy to allow the arduous labors of the Professional Reformers to be utterly lost, the following suggestions are offered for future guidance:

Nations and tribes of men differ in their treatment of the insane in so much as they differ in civilization. In some parts of Africa they dispose of the question *cito, tuto et jucunde*. When one becomes old, feeble or insane loving hands carry her out and deposit her in a convenient place to become food for wild beasts. The state or tribe is thus spared any expense and the consciences of philanthropic lawyers are not rasped by *cruel operations*.

In Australia, among the natives if a lunatic becomes troublesome they simply

go into executive session, and knock him, her or it in the head with a club. The question as to whether insanity is a disease or the result of disease is not entered into at all. The remedy is a specific for all forms of mental alienation. Pathology is ignored, prognosis is assured and treatment is routine enough to satisfy any committee on lunacy or its legal members. If these patients have tubes or ovaries tender, inflamed, adherent, degenerated, metamorphosed or decomposed “allee samee Melican man,” they can keep them.

They never raise the question of objectionable mutilation after recovery.

The “legal member” has given his august opinion that neither a patient, nor her guardian or relative can give consent to such an operation, for fear that she might be cured and then object to her mutilation.

What is to be done with our insane friends if this dictum of Dogberry holds good? The rule will apply to any other form of disease and, as no surgeon will be permitted to operate without the consent of some responsible person, and no one can by law give his consent, there is but one thing left to be done.

Philanthropists will have to furnish the “legal member” or some other professional humanitarian with a good large club, and turning him loose among these unfortunates, let him treat them after the Australian plan. Everything will then be lovely, all expenses to the state be saved, and the “l. m.” become the hero of his dreams.

A physician's library and instruments are exempt from execution. The insurance on the same is also exempt. So says a recent Supreme Court decision.—*Ex.*

Bellows—I don't believe you are anything of a doctor.

Dr. Surekill—Just ask my patients.

Bellows—I don't speak the dead languages.

TRANSLATIONS.

THE TREATMENT OF DIPHThERITIC ANGINA BY CHROMIC ACID.†

Lescure (*Jour. de Méd. de Paris*, Feb. 12, 1893) remarks that it is now clearly proven that the infectious manifestations of diphtheria are due, not to the invasion of the organism by the bacilli—even in the most rapidly fatal cases they are not found in the blood—but to the absorption of a toxine of peculiar virulence, secreted by the bacilli, which quickly spreads throughout the entire organism. The problem, therefore, reduces itself to the destruction of the false membrane (that is to say, the laboratory whence the microbe launches into the circulation the fatal toxines) before a sufficient dose to cause death has penetrated into the economy; this is the local treatment. As this dose ought evidently to vary with the resistance of the subject, it is necessary at the same time to increase this resistance; this is the general treatment. In other words, the treatment should fill two indications: 1. To destroy the false membrane, that is to say, to prevent the production of the toxines, *as quickly as possible*; 2. To combat the effects produced upon the system by the toxines which have already entered the circulation at the time of intervention.

Destruction of the false membrane may be accomplished by touching it with a solution of chromic acid, 40 to 100, repeating this once, twice, and very rarely three times in the twenty-four hours, according to the gravity of the case. At the same time the adjoining mucous membrane should be sterilized by painting it with tannic acid, six grammes to thirty of glycerine, repeated three or four times in twenty-four hours. At the same time also, the tincture of eucalyptus should be administered in three to ten gramme doses in the twenty-four hours according to the age. The general treatment consists of alcohol, nux vomica, quinine, milk, coffee, tea, suralimentation and oxygenation.

DESTRUCTION OF THE FALSE MEMBRANE, OPERATIVE TECHNIQUE.

The physician should supply himself with a caustic solution of chromic acid,

40 to 100. The application of weaker solutions is without result. The child, enveloped in a blanket, the arms extended on the body, is seated upon the knees of an assistant who faces the operator, and with his right arm supports the child, while with his left hand he supports the brow, immobilizes the head and holds it against his heart. On a table or chair to the right hand of the operator are placed:

1. A saucer containing some drops of the chromic acid solution and a small stick;
2. A glass half full of a soapy coal-tar solution diluted with water and containing a charpie mop. With the left hand the tongue depressor is introduced into the mouth of the child and pressed upon the base of the tongue. There is thus obtained a sufficient depression of the lower jaw to permit of easy exploration of the posterior pharynx. The mop charged with two or three drops only of the chromic acid solution is taken in the right hand and the false membrane is touched rapidly and lightly in order to avoid the healthy mucous membrane. The yellow coloration of the coated surface indicates that the application has been sufficient. This operation need not consume more than three or four seconds. The tongue depressor is now cleansed and the mucous membrane is matted out with the coal-tar solution two or three times. This neutralizes the excess of acid, and also has another action. The liquid uniting with the excess of acid forms a diluted solution which has a styptic action, and which produces around and upon the false membrane an albuminous precipitate which should carry with it a large portion of the toxic substance secreted by the bacilli and covering the mucosa. In the light cases, taken at the beginning when the false membrane has as yet but slight degree of thickness, one or two operations usually suffice to destroy it. In grave diphtheria it is necessary to renew the treatment several times; but rarely are more than three applications required in the twenty-four hours. In every case it is necessary to repeat them until the false membranes have disappeared. Under the influence of this treatment the false mem-

†Translated for THE MEDICAL AND SURGICAL REPORTER by W. A. N. Dorland, M. D.

brane does not disintegrate, but on the contrary it condenses, contracts, diminishes in extent, disappearing at the edges, and ends by coming off in one piece without leaving a subjacent wound, during one of the applications of tannin.

This employment of chromic acid in a dose so concentrated may seem daring to the first degree; nevertheless, it is exempt from all danger, and Lescure has employed it exclusively for five months without any disastrous consequences. This is explained by the valuable property possessed by this acid of not extending its action superficially beyond the point of application, and in depth beyond the thickness of the layer of liquid applied. Moreover, eminent practitioners such as Magitot and Iseibert, have used it successfully in affections of the mouth, and even have applied it to the larynx. It should undoubtedly be used with prudence and the applications made lightly, but by employing only the quantity of acid strictly required no danger will be done to the neighboring tissues.

STERILIZATION OF THE SURROUNDING FIELD.

For this purpose a glycerole of tannic acid may be employed, six grammes of tannin to twenty grammes of glycerine. Three or four paintings are made in the twenty-four hours, only one of which is made during the night. As an adjuvant to the direct sterilization obtained by this method, the tincture of eucalyptus may be given internally, three to ten grammes daily according to the age. This agent is eliminated largely by the mucous membranes, and by giving it in repeated doses every second hour its exhalation by the respiration is continuous as shown by the odor of the breath, and consequently the bronchial, tracheal, laryngeal and pharyngeal mucous membranes are constantly bathed in a material which not only is hostile to the multiplication of the bacilli and the propagation of the false membranes, but which also hinders the absorption of the toxines.

General Treatment.—The general treatment comprises two indications: 1. To sustain the general state of the patient so as to combat the poisoning; 2. To facilitate the destruction and elimination of the toxic products already absorbed. To meet the first indication an alimentation at once

reparative and light; must be insisted upon; bouillon, broths, beef juice, eggs, chocolate, purees, creams; at the same time the asthenia is met with nux vomica, quinine, alcohol, Bordeaux wine, Malaga wine, cognac, or rum, from thirty to sixty grammes in the twenty-four hours. To facilitate elimination of the toxic products by the renal emunctory, milk, coffee, tea, are given to the child, and in these the cognac or rum is given. Finally, the combustion of toxines in the blood is facilitated by increasing the quantity of oxygen absorbed, and for this purpose the most thorough ventilation possible is insisted upon, all the windows being opened to permit the rays of the sun to enter. Experience has shown the valuable effects of this practice.

Formulae:—

R	Acid Chromic.....	2 grammes.
	Distilled Water.....	5 "
R	Tannic Acid.....	6 grammes.
	Glycerine.....	30 "
R	Tinct. Eucalyptus.....	3 to 10 grammes.
	Gum Arabic Water.....	90 "
	Syrup of orange peel.....	30 "
To take in teaspoonful doses in the twenty-four hours.		
R	Tinct. of Nux Vom.....	4 drops.
	Ext. of Quinine.....	5 grammes.
	Malaga Wine.....	200 "
	Syrup of orange peel.....	100 "
Three tablespoonfuls in a day.		

The tincture of nux vomica should be given in such a way as to give the child at least three drops in the twenty-four hours. This dose may be raised to five, six or eight drops according to the age.

Results:—The number of cases treated to date by Lescure is fifty-four. He has not had a death. Among the fifty-four cases, five presented the characteristics of hypertoxic or rather infectious diphtheria, the diphtheric bacilli and the pyogenic streptococci of Barbier being mixed. The false membranes were soft and very thick, of a pale color, face swollen and livid, enlargement of the glands and edematous enlargement of the neck, fetid breath, severe pain, intense fever, albumin in the urine, somnolence, a very pronounced general asthenic state. The patients were twenty-seven months, three years (two), four years, and seven years of age. The duration of the sickness was from nine to fifteen days.

ADVANTAGES OF THE TREATMENT.

1. *The rare intervention and short duration of each application.*—The applications of chromic acid are only needed

once or twice in the twenty-four hours, and the paintings with tannic acid only three or four times. The applications therefore, are made only every three or four hours at the most. This permits the saving of the forces of the child and permits it to sleep.

2. *Absence of pain.*—This treatment is absolutely painless and does not determine any inflammatory reaction in the throat.

3. *The integrity of the mucous mem-*

brane is absolutely guarded.—The false membrane in falling off under this method of treatment does no leave any raw patches which may act as ports of entrance for the poisonous products.

4. *Finally this treatment is very easy of application.*—While the applications should always be made by the physician himself, as generally there are only one or two in the twenty-four hours this can readily be satisfactorily arranged.

ABSTRACTS.

A FEW PLAIN WORDS ON GLAUCOMA.

The relatively large number of cases of absolute and hopeless blindness from neglected glaucoma coming under my observation, writes Dr. Lewis, of Raleigh, N. C., has suggested to me the propriety of making an effort to do something in the way of prevention of such sad occurrences. Blindness from this cause is peculiarly deplorable for the reason that the afflicted one is not only cut off from all perception of light—even a deprivation that only the blind that retain the power of discriminating between day and night can fully appreciate—but is a sufferer, in many instances, from repeated and long-continued attacks of severest pain.

For our purpose it would be best to consider only the three ordinary forms of the simple or chronic, the subacute and the acute inflammatory. The symptoms common to all forms are failure of sight, increased tension or hardness of the eyeball, dilated pupil, and contraction of the visual field especially toward the nose. The most characteristic of these is increased tension, which is to be ascertained by gently palpating the globe through the upper lid as the patient looks at his feet, very much in the same way as for pus in a suspected abscess. If not familiar with the feeling of the normal eye, a comparison should be made with the other eye, if unaffected, or with the examiner's own. The next most important symptom is dilatation of the pupil, particularly if it does not respond to light. A fact of great assistance in a negative way, in helping to a correct diagnosis, is that the subject of glaucoma is almost sure to be past mid-

dle age, or old enough to wear spectacles for reading. And the first thing one suffering from chronic glaucoma, as a rule, notices is that his spectacles do not suit him as well as they once did, and that he cannot find any that will bring his sight up to the original standard. The need of frequent changes in his glasses is often a premonitory sign. He will then complain that at times there is a fog or haze over his sight, lasting for a greater or less period and then passing off entirely for a while, only, however, to return again at shorter intervals, denser in character and hanging over him longer. While this fog is present he will tell you, usually, that when he looks at a lamp or other light it seems to be surrounded by colored rings haloes or rainbows—a phenomenon only found in glaucoma, except when produced by mucous on the cornea, which can be easily removed by winking. Pain, if present at all, will be slight and occasional. A superficial inspection of the eye will show the sclerotic white, the cornea clear and bright, and, in a word, the eye perfectly normal in appearance, save a slight dilatation and some sluggishness of the pupil. The tension will probably be a little increased, and the field of the vision somewhat narrowed.

In the subacute form, after, in all likelihood, a few premonitory attacks embodying the symptoms just enumerated as belonging to the chronic, there will be a more rapid failure of sight—pain in, but chiefly around, the eye, over the brow, in the temple, down the side of the nose, and, sometimes, all over the side of the

head, will be complained of—the globe will be very distinctly hard—there will be some redness of the ball, or rather dusky character, most marked just behind the sclero-corneal junction—the cornea will look rather steamy—the anterior chamber will generally appear shallow, the pupil will be dilated and probable oval in shape, and, instead of being black, it will be of a yellowish green color.

The acute form is simply an exaggeration of the subacute. The onset is more rapid—the tension greater—the pain more severe—the redness more intense, in some instances extending to the whole conjunctive with a swelling of the lids—occasionally there is a photophobia—the pupil is more widely dilated, though not necessarily *ad maximum*, and fixed—the cornea looks more hazy and insensible to the touch of a light, soft object, as a feather or wisp of tissue paper—and sometimes there is fever with nausea and vomiting. Inasmuch as the mistake has been made, I will take the liberty of saying that should you have a case of supposed remittent fever, who, at the same time, has had a bad eye, do not be satisfied with your diagnosis until all doubt as to the nature of the ocular trouble is removed, and *do not wait for him to recover from the fever, or "bilious attack," before attending to his eye.*

The diseases with which inflammatory glaucoma might be confounded are iritis, conjunctivitis, cataract, inflammation of the cornea, and neuralgia. There are many resemblances between acute iritis and acute glaucoma, and there are many differences, but the similar features, unfortunately, are of a coarser and more easily recognized character than the dissimilar. In order to avoid confusion, I will rest the differential on two symptoms, or signs, only—the state of tension and of the pupil. While in iritis the tension is sometimes increased, it amounts to practically nothing, but in glaucoma it is the pathognomonic symptom, and in the inflammatory form—with which alone iritis could be confounded—it is almost certain to be very distinct and pronounced. The pupil in iritis, if changed at all in size, is smaller than the normal, but in glaucoma it is almost invariably larger than natural, and, in an immense majority of cases, very much larger. If in doubt compare with sound eye, should there be one or

with a healthy eye in another individual of about the same age and in the same light. Never fail, therefore, to examine more carefully the pupil in every red eye belonging to an elderly person, and particular if that eye be free from a mucopurulent or purulent discharge—the presence of this discharge being the characteristic symptom of conjunctivitis.

In conjunctivitis the redness of the globe increases from before backward, while in glaucoma, as well as in iritis just the reverse is true. In conjunctivitis, too, the sight is scarcely, if at all, impaired—in glaucoma it is apt to be very bad.

It is of vital importance that glaucoma and iritis should not be confounded with one another, for the remedy appropriate to each is generally positively injurious to the other, in some cases actually exciting an attack in a healthy eye predisposed to that particular affection. If the pupil be carefully examined and its size noted the mistake in the application of remedies could not well be made, for it is the most elementary common sense, it seems to me, for every one using remedies directed to the pupil to attempt to contract a pupil that is too large and to dilate one that is too small. Attention to this simple rule would insure practically the use of a myotic, eserine sulphate or pilocarpine murate, in glaucoma, and a mydriatic, atropia sulphate, in iritis.

Having made the diagnosis of glaucoma its early management is very simple. It consists in the *immediate* use locally of a myotic, sulphate of eserine, a drop or two of a solution of a strength varying from one to four grains to the ounce, or pilocarpine of double that strength, in the eye every hour until the pupil contracts, pain is relieved and sight improved, and continued afterwards three or four times a day until the trouble has passed off. Hot applications, purgatives, hypodermic injections of pilocarpine, etc., are sometimes helpful, but such uncertain palliatives should not be depended on, except only when nothing better can be done. Should the pupil not respond to the myotic and a marked alleviation of the symptoms occur in twenty-four hours, or if its use increase the pain and inflammation, as it sometimes does, an iridectomy or sclerotomy, preferably the former, in my opinion, should be done at the earliest possible moment. Acute glaucoma is a disease

that allows no dallying in its treatment—the price of sight is *promptness*—and,

eserine or pilocarpine failing, the knife is the only hope.—*Charlotte Med. Jour.*

THREE CASES OF PUERPERAL ECLAMPSIA.

Dr. John Marriott reports three cases:

CASE 1. June 2d, 1890. Patient aged 39, a XI para. The author was told that she had ten violent fits during the night and had not spoken for hours. He found her in deep coma and tongue badly bitten. Cyanosis was extreme and she breathed with difficulty. The pulse was feeble and intermittent. Urine drawn by catheter proved to be highly albuminous. There was no sign of commencing labor. As she immediately afterwards had two more fits and was evidently in a desperate condition, the author proceeded to attempt delivery. The os was fortunately soft and yielded to digital dilatation so that in about twenty minutes he was able to turn, and in about another quarter of an hour both child and placenta had been expelled. The patient flooded violently and, unfortunately, the author had no ergotine with him and she could not swallow. The hemorrhage was arrested by hot water injection. The child did well. The mother lay in deep coma for several hours, but had no more fits. She recovered without a bad symptom. After a few days the urine was found to contain no trace of albumen. She has remained in good health ever since, earning her living as a washer-woman.

CASE 2. August 29, 1891. The patient, aged 21, had five fits in two hours. She had been ailing for some weeks, anemic and suffering from dyspnoea, but her condition was not suspected. The author found her unconscious with a portion of the tongue bitten clean out. Finding the vulva oedematous and the legs slightly so, he drew off the urine and found it nearly solid with albumen. She appeared to be about four months pregnant and the foetal movements were perceptible. Soon afterwards she had another fit during which respiration ceased and was with difficulty re-established. He placed two drops of croton oil on the tongue and administered a little chloroform, proceeding then to dilate the os with the finger. The cervix was long

and very rigid, but in nearly an hour he succeeded in introducing six laminaria tents. After this she had no more convulsions, but came round sufficiently to a full dose of chloral. The oil acted vigorously and labor pains came on regularly. When the tents had been in twelve hours the author removed them and the foetus immediately followed. There was no difficulty with the placenta and no hemorrhage. She had complained much of headache and giddiness for the last two hours, but was quite conscious. About ten minutes after the birth of the foetus she was suddenly seized with violent dyspnoea, which lasted about a quarter of an hour. There were no abnormal physical signs to be discovered in the thorax. She had several of these attacks during the next few days, but less severe. They seemed to be uramic in nature. The urine continued albuminous and she had bad headache for sometime. She also developed a rough systolic murmur at the left apex, evidently caused by dilatation of the ventricle as the apex became displaced downwards and outwards. The pulse showed increased tension, and the oedema of the vulva and legs remained stationary for quite a fortnight, after which it slowly declined. The endocardial murmur slowly disappeared, and the albumen decreased *pari passu* with the general improvement.

CASE 3. October 3, 1891. The patient was an extremely pale, thin woman, aged 38, of a phthisical family and never enjoying good health. She had ten children, subsequently two miscarriages. On the morning of October 3rd—she had a fit, and soon afterwards had three more without regaining consciousness. The author found her quite blind and only feebly conscious on his arrival at 8.30. She made some attempt to speak, but was incoherent and groaned often as if in pain. She also resisted being moved or touched. Almost immediately she had another fit, which began with conjugate deviation of the head and eyes to the left and complete arrest of respiration, the whole body

becoming perfectly rigid. In about fifteen seconds violent clonic spasms succeeded, affecting the whole body simultaneously. These continued with unabated strength for about forty-five seconds and then suddenly ceased. Breathing was extremely shallow and sighing, and the patient much cyanosed. From this point she gave no sign of consciousness and could not be roused. The author found the urine highly albuminous and so at once commenced digital dilatation of the os. Being constantly interrupted by fits he gave a small quantity of chloroform at intervals in the hope of moderating their violence, but it did not appear to have much effect. He found the os very rigid, as it had not been fully dilated for four years. Consequently he was only able to get it to admit three fingers and to rupture the membrane. On returning three hours later the author found that no progress had been made. She had had numerous fits and was obviously in a critical condition, the breathing being of marked Cheyne-Stokes' type; the pulse imperceptible at the wrist, extremities cold and the larynx much obstructed with mucus, which she made no effort to dislodge. There was no return of consciousness. As a last resource the author

attempted to apply the forceps through the half dilated os, and on getting them fixed injected hyperdermically a full dose of ergotin and a minim of liquor strychninæ. The fœtus, though near term, was very small and was extracted in a few minutes. The patient's condition was so critical that he was obliged, just before the birth of the child, to inject two syringefuls of brandy under the skin of the abdomen. He waited nearly half an hour before attempting to remove the placenta, knowing the patient's tendency to flood, but the uterus contracted firmly and gave no trouble whatever. She had two more convulsions between the delivery of the fœtus and placenta, not so severe as those preceding, and after the expulsion of the placenta there was absolutely no recurrence. She remained unconscious for about eight hours, but swallowed small quantities of brandy and milk when poured into the back of the throat. Later she fell into a natural sleep. Suppuration followed in the track of the injections of brandy, but not in that of the ergotin. She made excellent recovery, but the fœtus was dead. A week after delivery there was no trace of albumen in the urine, but the urea was deficient being only .07 per cent.—*Lon. Lan.*

CURRENT LITERATURE REVIEWED.

THE MEDICAL CHRONICLE

of Manchester, England, for February contains an interesting paper by Dr. Thomas Harris on "Some Clinical and Post-mortem Observations on the Cardiac Dullness in Cases of Mitral Disease, and on the Relative Size and Position of the Cavities of the Heart." The different points discussed by the author are illustrated by reports of cases, and also by diagrams of the area of dullness over the cardiac region in the several cases.

Dr. W. Roger Williams continues his communication on

Observations on the General Pathology of Cancer—Especially of the Breast,

this number being devoted to the prevalence of cancer and its increase. "Cancer," he says, "has steadily increased during the last half century and is still increasing, and this in spite of diminution in the general death rate. Insanity also is on the increase." This statement he fortifies by tables from the office of the Registrar General for the years 1838 to 1890 inclusive, and also the death rate from cancer in other countries. "The augmented cancer mortality has coincided with progres-

sive population, increased national wealth and marked improvement in the general well-being." It is impossible to consider this in any other light than cause and effect. The author also points out the decline in the death rate from phthisis and other tubercular diseases, which decline he regards as due to improved hygienic conditions and the very causes which have increased the cancer mortality.

Dr. Ernest S. Reynolds considers the causation of the deep reflexes (knee jerk, etc.) which he terms "Myotatic Contractions." He sums up as follows: "In the production of myotatic contractions, although the direct increase of tension by tapping the muscle or its tendon is probably the best way of inducing the phenomena, yet that in many cases, this increase can be caused very directly by the physical diffusion of vibration transmitted even from a distant part of the body." The contractions he thinks are not true reflex actions but are due to an increased tension of muscles in a state of myotatic irritability.

In the "Clinic" department Dr. W. H. Brazil reports a "Case of Gunshot wound of the Abdomen; Operation; Recovery." The

bowel was perforated by the ball in four places which were closed with Lambert sutures of catgut. The case recovered promptly, with no complications except a small fecal fistula which quickly closed.

Dr. W. Roger Williams reports a case of

Laparotomy, with Excision of the Appendix, For Acute Perforative Appendicitis.

The patient presented symptoms of appendicitis; constipation, dullness and pain in the right flank, though the principal tenderness was in the left iliac region, and at no time was it possible to detect any tumor in the region of the appendix. At the operation the appendix was found enlarged and with a perforation at its apex. In the pelvis at the position of the apex of the appendix, there was a collection of pus the size of an orange. On opening the appendix a fecal concretion the size of a date stone was found. The patient survived the operation six hours.

Severe Crush of the Chest.

A case is reported by Dr. J. M. Crawshaw, as the result of the patient having been crushed between two carts. On admission to the hospital the patient was suffering severely from shock and complained of great pain over the sternum and the left side of the back. It was impossible to feel the ribs, owing to the extensive emphysema present, which increased until it extended from the temporal regions of the scalp down to the wrists and to within three inches of the angles. The patient survived eight days. At the post-mortem the first six ribs on the left side were found fractured, the first through the neck, the lower ones through the angles. There was a tear in the parietal layer of the pleura above the first rib. The left lung was collapsed, solid, with two large ruptures in its upper lobe. The right lung was unimpaired. Two unusual features about the case were the slight amount of hæmoptisis and the fracture of the first rib without the clavicle being broken as well.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

for March contains a paper by Dr. S. Weir Mitchell on

Hysterical Rapid Respiration, with Cases; Peculiar form of Rupial Skin Disease in an Hysterical Woman.

The form of breathing is largely upper costal, sometimes exclusively so, and as a rule slight in amount. Early in the case the patient is ignorant of the existence of the symptom, but later, when the attention is called to it, the respiration rate is increased by any excitement—as the approach of nurse or doctor. Usually it is absent in sleep and the type of breathing is quite impossible as the result of voluntary effort. The paper gives the report of the cases in full and the tracings of the respirations are contrasted with the attempt of a healthy man to simulate rapid breathing. The rupial affection occurred in an hysterical girl and was pronounced by Dr. Duhring to be due to a degeneration of the nervous system. It was not

syphilitic nor sarcomatous, but due to the disturbed state of the whole nervous system.

Dr. George H. Edebohls contributes a paper on

Movable Kidney; with a Report of Twelve Cases Treated by Nephrorrhaphy.

The author states that he believes the disease to be more common than is usually supposed, stating that out of 500 women examined he found it to exist in 90. Not every movable kidney however produces symptoms and often the possessor is not aware of his ownership. The author's theory as to its causation is the absorption or atrophy of the peri-renal fat. The subject is of interest to the gynecologist on account of its frequency in women as compared with men, and also because its symptoms are so similar to those accompanying lesions of the genital organs. Its frequency in women may, however, be overestimated on account of abdominal palpation being more frequently practiced on women than on men. In the majority of cases it occurs on the right side though Dr. Edebohls has seen it also on the left. Why it should occur on one side more than on the other he is unable to say. Perhaps the right kidney is more exposed to displacements on account of its position immediately below the liver, a heavy organ subject to great fluctuations in size and weight. "The morbid phenomena due to a movable right kidney in its earlier stages are digestive disturbances, chronic in character; general nervousness; epigastric pain, usually located somewhat to the left of the median line, at or near the free border of the left costal cartilages; cardiac palpitation; inability to feel comfortable or to sleep when lying on the left side." The diagnosis is easy and is made by the discovery of a movable tumor of the size, shape and consistency of the kidney, in the right hypochondriac or lumbar regions, or in the iliac fossa. In the treatment, a bandage is generally recommended, but the author thinks it ranks a poor second to nephrorrhaphy. A well-fitting, rather tight corset answers well in males, and in women in whom no contra-indication exists in the condition of the sexual organs. The paper is to be continued in the next issue of the journal.

Dr. H. Augustus Wilson discusses "Fixation after Excision of the Knee." After reviewing the literature on the subject the author presents the following conclusions: Metallic bone-sutures will secure the most efficient internal approximation. They should never be removed unless some serious condition demands it. The entire leg should be kept free from the patient's control by an external splint for from four to six weeks. The most important element in the treatment is the prolonged use of a rigid brace.

Dr. Norman Bridge in a

Note on a usually overlooked condition in the Grave Convulsions of Infancy and Childhood.

divides the seizures into two classes. One is a true epileptic seizure, coming on suddenly without apparent accompanying illness, and provoked by some slight physiological disturbance, such as indigestion. In the other

form the fit is prolonged, a true eclampsia. The most notable difference clinically, is the presence of high fever (102° to 108° F.) in the eclamptic form. In the treatment cool bathing is advocated, especially as the temperature is reduced by this means. Of drugs he regards hydrate of chloral as the one most useful. Next comes opium. The bromides are useless.

In an article on "Cocaine in the treatment of Variolous and Varioloid Infection," Dr. Edward Pepper strongly advocates the use of this agent; stating, that by its use variolous and varioloid poisoning can frequently be arrested in a marked degree.

Dr. Henry J. Garrigues reports a successful case of "Symphysiotomy" illustrating the paper with cuts of instruments used, and photographs of deformed pelvises.

Other papers in this month's issue are "A question of 'Water, Ethics, and Bacteria,'" by Albert R. Leeds, Ph. D. The question of water analysis is entered into and discussed together with the best means of purifying the drinking supply of a large city. Dr. F. X. Dercum reports "Two Cases of Akromegaly," with remarks on the pathology of the affection. The report is illustrated with photographs of the patients.

THE AMERICAN JOURNAL OF OPHTHALMOLOGY

For January contains a long letter from Dr. Swan M. Burnett, of Washington, in reply to one by Dr. A. E. Davis, in the *N. Y. Med. Jour.* for November 19th, 1892, under the heading of "Ophthalmometry in America."

The answer is in a good humored but decidedly caustic strain. It would seem that the energy expended in a mere priority fracas could be utilized with some profit in other ways. Surely the space thus wasted could have been filled with matter of some benefit to the profession.

"Two cases of Gonorrhœal Iritis" are reported by Dr. Adolf Alt.

There is also a translation of a clinical lecture by Prof. Panas upon

"Sympathetic Ophthalmia."

Reference is made in it to the experiments of Leber and Deutchmann by which they claimed that the inflammation was propagated from one eye to the other by the optic tract. Panas proceeds to say "But these experiments have been done many times since, and the results are not at all sure, so that we must not accept his theory as proved. At the last congress at Heidelberg, Schmidt, Pfueger, Lagneur and others spoke against it. If we cannot accept this theory, we cannot admit the advisability of an operation or attempt to prevent sympathetic ophthalmia by section of the optic nerve, or resection combined with abrasion of the ciliary nerves and vessels. We can add that this operation often results in an hematoma of the orbit, marked protrusion of the globe, and death by meningitis, and that this happens much more often than has been said or written." The writer considers enucleation the most

reliable means of preventing sympathetic ophthalmia. He also employs mercurial treatment either by "rubbing the ointment into the eye, or by hypodermic injections."

THE BRITISH JOURNAL OF DERMATOLOGY.

The February number contains two articles.

Dr. Alfred Francis in a paper on

Lymphangioma Circumscriptum Cutis

proposes (1) to describe the cases which have come under his own observation and some others, and (2) to attempt to group the recorded cases, basing their classification partly on their anatomical and partly on their clinical features. Though they all appear closely allied yet, for descriptive purposes, they are divided into the following groups and sub-groups:

Group I. Lymphangioma simplex.

Group II. Lymphangioma cavernosum.

Group III. Hæmatolymphangioma (L. simplex et varicosum et cavernosum.)

Group IV. Lymphangioma (s. et v. et c.) with pachydermia.

The paper is continued.

Dr. T. Colcott Fox offers an interesting and unique case of

Keratosis of the Palms and Soles, Probably due to Arsenic.

The patient, a young man, aged 20 years, sought advice on account of a chronic intractable thickening of the skin of the palms and soles. Six years previously, shortly after his first and only connection with a woman, the patient suffered from multiple "sores" on the penis. At this time he did not consult a doctor, but fifteen months later, after a sea bath, he discovered a red eruption which developed into blebs. This eruption commenced on the chest, became generalized and continued off and on for some time. The bullæ formed crusts of considerable size and left faint scars. Syphilis appears to have been diagnosed by several well-known practitioners, and the term *rupia* was applied to the eruption. The patient states that he never had a sore throat or tongue, or bubos. He took iodide of potassium on one occasion only, but it "poisoned him." Mercury was administered in one form or another for four years and three-quarters, and arsenic for at least four years. Thus it is gathered from his prescriptions that the patient was ordered five minims of liquor arsenicalis thrice daily in October, 1888; fifteen minims of Donovan's solution thrice daily in November, 1888; about two and a half minims of liquor arsenici hydrochlorici thrice daily in February, 1889; then arsenious acid and liq. arsenici hydrochlorici for a time, and finally liq. arsenicalis in four minim doses, thrice daily, down to about September, 1892.

When the patient consulted the doctor in November, 1892, he informed him that the exhibition of green iodide of mercury pills just before a prolonged sea voyage, the discontinuance of other medicine, and the sea voyage itself, had greatly improved his health. All bullous eruptions had ceased

and have remained absent. He was still rather pale. His palms and soles were greatly thickened and disfigured, and in such a manner as to suggest an arsenical origin. His face had a peculiar but slight muddy tint, which might well have escaped notice. The neck was rough and dirty-looking, and his body much mottled with dirty-looking pigmentation, which was probably due to arsenic and not to pre-existing eruptions. The skin, generally, of the limbs and body was harsh and dry, with indications of faint desquamation, but without any psoriasiform patches on the elbows or elsewhere. There was an indication of a scar on the glans penis, but no other objective sign of syphilis, unless the condition of the palms and soles be considered such. The latter regions presented a considerable thickening of the epidermis, simulating hereditary congenital keratosis.

The treatment consisted of local remedies only. The palms and soles thoroughly soaked in soda and hot water each day, and when the epithellum was sufficiently macerated, vigorously attacked with pumice stone. Then Unna's strong salicylic acid plasters were applied night and morning, and worn throughout the twenty-four hours at first. Under this treatment the condition rapidly ameliorated, and soon there were only isolated warts to deal with. When the patient was seen last the hands and feet looked quite cured and had wonderfully improved in his general health.

The causation of this palmar and plantar keratosis seems to have been either syphilitic or arsenical, though we must remember that the palms and soles assumes a somewhat similar condition under other influences such as in congenital pemphigus, and perhaps hyperhidrosis. We are not in a position, however, as yet to estimate the influence of the arsenic frequently administered in such cases.

We know, however, that administration of arsenic, in certain persons, excites, amongst other effects, peripheral nerve and vascular lesions, evidenced particularly in the palms and soles.

NEWS AND MISCELLANY.

The International Congress of Charities, Correction and Philanthropy.

We invite the attention of our readers to the following circular, and would earnestly urge members of the profession to participate in the proposed congress:

One of the series of International Congresses to be held in Chicago in 1893 is to be devoted to the subjects of Charities, Correction and Philanthropy, and the third section of this is to consider all matters relating to the hospital care of the sick, the training of nurses, dispensary work, and first aid to the injured. The Committee of Organization of the Congress has appointed Dr. John S. Billings, Surgeon U. S. Army, as Chairman of this Section, and Dr. Henry M. Hurd, Superintendent of the Johns Hopkins Hospital in Baltimore, as its Secretary, and has authorized and requested them, to complete its organiza-

tion, to extend invitations and to prepare a programme for its work. Miss Isabel A. Hampton, Superintendent of the Training School for Nurses of the Johns Hopkins Hospital, has been appointed chairman of that part of the work of the Section which relates to the training of nurses.

This Section will hold five sectional meetings of about two hours each, commencing June 12, 1893, and will also have charge of one of the general sessions of the Congress, viz: that held on the morning of June 14.

It is desired that this shall be a truly international gathering for conference on the subjects allotted to this Section, and all who are interested in hospitals, in training of nurses, in dispensaries, or in first aid to the injured, are cordially invited to be present, to contribute papers and to take part in the discussions.

The papers and proceedings will probably be printed as a separate volume, and it is hoped that this will represent the best methods and the best work in each of these departments in all parts of the world.

The following are suggested as subjects for special consideration in papers to be prepared:

1. Hospital organization—governing bodies—relations of the medical staff and of nurses' training schools.
2. Hospital finances—means of support—mode of accounts—cost.
3. Plan and construction of recently built general hospitals, embodying the latest improvements.
4. Relations of hospitals to increase of knowledge, to medical education, and to the medical profession. Hospital records, statistics and reports.
5. Pay patients in hospitals.
6. Isolating wards and hospitals for contagious diseases.
7. Hospital diets, dietaries, kitchens, etc.
8. Hospital amphi theatres and operating rooms.
9. Hospital laundries and disinfecting establishments.
10. Army and navy hospitals—emergency hospitals in time of epidemics—temporary and movable hospitals.
11. Small and special hospitals, cottage hospitals, school hospitals, private hospitals, sanatoriums, etc. Convalescent hospitals, and what to do with incurables.
12. History and present condition of hospitals in the large cities.
13. Training schools for nurses.
14. Dispensaries—relations to the public and to the medical profession. Dispensary records.
15. First aid to the injured. Associations for best means of popular instruction in and its place in general education.

Persons desiring to present papers, or to share in the discussions of this Section, are requested to communicate with the Secretary at once. The period of time allotted for the preparation of the programme is necessarily brief, and it is essential that all who are willing to assist in this work should act promptly.

Address all communications to DR. HENRY M. HURD, The Johns Hopkins Hospital, Baltimore, Md.